069569 OCT 23 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29693

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows early injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT) FIRST	LEMUEL	MIDDLE WILLARD	LAST AMOSS	2a. DATE OF DEATH MONTH DAY YEAR	October 18, 1987
2b. HOUR	9:30 AM				
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH MONTH DAY YEAR	July 15, 1901
6. AGE (IN YEARS LAST BIRTHDAY)	86 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 DAY HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	
9. BALTIMORE CITY OR COUNTY OF DEATH	Harford County MD				
10. CITY OR TOWN OF DEATH	Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	2110 Pleasantville Road	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Farmer
12b. KIND OF BUSINESS OR INDUSTRY	Dairy				

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Fallston		2110 Pleasantville Road 21047

14. FATHER'S NAME FIRST	Lemuel	MIDDLE Howard	LAST Amoss	15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Isadora LAST Benson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	no	(IF YES, GIVE WAR OR DATES)	--	16b. SOCIAL SECURITY NO. 212-38-0026
17. INFORMANT ADDRESS	Dr.Willard P.Amoss, 2018 Pleasantville Road Fallston,Md. 21047			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Respiratory Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Obstructive Pulmonary Disease	6 months.
DUE TO, OR AS A CONSEQUENCE OF (c)	Brain stem CVA, Aspiration Pneumonia, Anaemia.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a: Chronic Anemia - Low Pressure Hydrocephalus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from March 19 87 to 10-18 19 87 that (I) (we) last saw the deceased alive on 10/18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED 10-19-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. D. Parekh, M.D.	22e. ADDRESS 1908 Harford Road, Fallston,Md. 21047		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	Oct.20,1987	23c. NAME OF CEMETERY OR CREMATORY: Fallston U.M.Cemetery
23d. LOCATION CITY OR TOWN	Fallston	COUNTY	Harford	STATE Md.
24. FUNERAL DIRECTOR NAME AND ADDRESS	Howard K. McComas III, Abingdon,Md. 21009	25a. DATE REC'D. BY REGISTRAR	OCT 22 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Kimball

BP_____

DHMH - 16 60M 7-84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR — REG. NO. 29694

0701 51 OCT 29 87

1. DECEASED NAME (TYPE OR PRINT) FIRST: Elizabeth	MIDDLE: Badger	LAST: Averill	2a. DATE KNOWN OF DEATH ESTIMATED X: MONTH 10 DAY 23 YEAR 87	2b. HOUR			
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: MONTH 8 DAY 27 YEAR 07	6. AGE (IN YEARS LAST BIRTHDAY): 80 YRS	IF UNDER 1 YR.: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 23 YEAR 87	2d. HOUR: 7p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD				
10. CITY OR TOWN OF DEATH: Aberdeen	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 408 Paradise Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS: 408 Paradise Rd. 21001			
14. FATHER'S NAME FIRST: Ebert	MIDDLE: A.	LAST: Badger	15. MOTHER'S MAIDEN NAME FIRST: Lulu	MIDDLE: F.	LAST: Sanderson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-38-7053A	17. INFORMANT ADDRESS: Ebert Badger, Box 166 Rt. 3, DuBois, Pa.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry ☐, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E. Renjel TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 10/23/87

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St. Havre De Grace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/27/87	23c. NAME OF CEMETERY OR CREMATORY: Morningside Cemetery	23d. LOCATION CITY OR TOWN: DuBois	COUNTY: Clearfield STATE: Pa.
24. FUNERAL DIRECTOR NAME, ADDRESS: Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR: OCT 28 1987	25b. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

68905 OCT 19 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29095

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other [illegible] event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Fern	MIDDLE: Madeline	LAST: Barker	2a. DATE OF DEATH MONTH DAY YEAR: 10 13 87	2b. HOUR: 8:00 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 4 5 27	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY: Own home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Cecil	Conowingo	YES ☐ NO ☒	880 Ragan Road/21918

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Fred Walter	Evelyn Beal

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	----------	220-20-7744	Arthur R. Barker 880 Ragan Road Conowingo, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic Ht Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes Mellitus.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (~~this hospital~~) attended the deceased from 10/6 19 87 to 10/13 19 87 that I (~~we~~) last saw the deceased alive on 10/12 19 87 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. I (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
Andrew Nowakowski	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/13/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ANDREW NOWAKOWSKI	MD	22e. ADDRESS: 125 N. MAIN ST. BEL AIR MD	21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/16/87	Conowingo Baptist	Conowingo Cecil Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR SIGNATURE
Harkins Funeral Home, Inc. 600 Main St. Delta, PA	OCT 16 1987	Julia Davidson-Randall

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

0677 30 ET-7 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 87 29096

1. DECEASED NAME (TYPE OR PRINT): FIRST HILDA MIDDLE M LAST BLACKBURN

2a. DATE OF DEATH: MONTH 10 DAY 01 YEAR 87

2b. HOUR 12:30 PM

3. SEX: Female

4. RACE: Cauc.

5. DATE OF BIRTH: MONTH Oct. DAY 16 YEAR 1923

6. AGE (IN YEARS LAST BIRTHDAY): 63 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Clerk

12b. KIND OF BUSINESS OR INDUSTRY: Del.Stamp & Coin Shop

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Cecil

13c. CITY OR TOWN: Port Deposit

13d. INSIDE CITY LIMITS? YES X NO ☐

13e. STREET ADDRESS / ZIP CODE: 58 North Main St. 21904

14. FATHER'S NAME: FIRST G. MIDDLE Alvin LAST West

15. MOTHER'S MAIDEN NAME: FIRST Jessie MIDDLE M. LAST Santmyers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES): -----

16b. SOCIAL SECURITY NO.: 216-20-9702

17. INFORMANT ADDRESS: Clifton M. Blackburn, Jr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Metastatic Abdominal carcinoma, unknown primary — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF

(b): /

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Aug 17, 19 87 to Oct 1, 19 87 that (I) (we) last saw the deceased alive on Sept. 30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Arthur Finley Jr

DEGREE: MD

ATTENDING PHYSICIAN X MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: Oct. 5, 1987

23c. NAME OF CEMETERY OR CREMATORY: Hopewell cemetery

23d. LOCATION: CITY OR TOWN Port Deposit COUNTY Cecil STATE Maryland

24. FUNERAL DIRECTOR (NAME): Lee A. Patterson & Son

ADDRESS: Lee A. Patterson & Son, Perryville, Maryland

25a. DATE REC'D BY REGISTRAR: OCT 06 1987

25b. REGISTRAR'S SIGNATURE: Lee A. Patterson & Son

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please forward certificate papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "yes," item 18 should show any injury, or other traumatic event, the medical examiner must be notified before

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 60M 7 84
(VRA 15, 4)

067743 OCT 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 29071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked on Item 18, show any injury, or other traumatic event, the medical examiner has been notified.

1 DECEASED NAME (TYPE OR PRINT): FIRST Charlotte MIDDLE F. LAST Boddy

2a DATE OF DEATH: MONTH 10 DAY 4 YEAR 87 — 2b HOUR 1005 AM

3 SEX: Female

4 RACE: Black

5 DATE OF BIRTH: MONTH April DAY 8 YEAR 1947

6 AGE (IN YEARS LAST BIRTHDAY): 40 yrs. YRS — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS: HOURS MIN

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b CITIZEN OF WHAT COUNTRY?: U.S.A.

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10 CITY OR TOWN OF DEATH: Havre de Grace

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Dietetics Svc.

12b KIND OF BUSINESS OR INDUSTRY: V.A.M.C., Perry Point, Md

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Maryland — 13b COUNTY: Cecil — 13c CITY OR TOWN: Perryville — 13d INSIDE CITY LIMITS? YES [ ] NO [X] — 13e STREET ADDRESS / ZIP CODE: 10 Brookside Dr. 21903

14 FATHER'S NAME: FIRST Howard MIDDLE LAST Williams

15 MOTHER'S MAIDEN NAME: FIRST Mildred MIDDLE LAST Kinslow

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): ----------

16b SOCIAL SECURITY NO.: 212-50-5017

17 INFORMANT: Jack T. Boddy — ADDRESS: Perryville, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): END STAGE DILATED CARDIOMYOPATHY — 1½ Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a DATE OF OPERATION — 19b CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a AUTOPSY? YES [ ] NO [X] — 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] — 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: C Eck — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] — 22c DATE SIGNED: 10/4/87

22d PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES R. ECK JR. — 22e ADDRESS: Aberdeen Md #21001

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b DATE: Oct. 8, 1987 — 23c NAME OF CEMETERY OR CREMATORY: Mt. Zoar Cemetery — 23d LOCATION: Conowingo Cecil COUNTY Maryland

24 FUNERAL DIRECTOR (NAME): Lee A. Patterson & Son — ADDRESS: Lee A. Patterson & Son, Perryville, Maryland

25a DATE REC'D BY REGISTRAR: OCT 06 1987 — 25b REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

BP_____

DHMH 16 60M 7/84
(VRA 15, 4)

068879 OCT 19 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29078

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: PRESTON, Middle: ONYER, Last: ~~Preston~~ Bossom				2a. DATE OF DEATH Month/Day/Year: 10/11/87.	2b. HOUR: 6:15A M
3. SEX: MALE	4. RACE: White	5. DATE OF BIRTH Month/Day/Year: 07 21 16	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	IF UNDER 1 YEAR Months/Days	IF UNDER 24 HRS. Hours/Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford.		MD.
10. CITY OR TOWN OF DEATH: Fallston.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Carpenter	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Forest Hill	YES ☐ NO ☒	710 Walters Mill Rd. 21050

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Raymond / / Bossom	Madeline / / Rhoten

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		213-01-1891	Pauline Bossom	SAA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Respiratory Failure COPD. Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF (b): Gastric ulcer - bleeding. CA Lung. (Squamous).

DUE TO, OR AS A CONSEQUENCE OF (c): Staph Epi - Bacteraemia.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / Months / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. / MONTH / DAY / YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (this hospital) attended the deceased from 19 83 19 ____ to 10-11 19 87 that I (we) last saw the deceased alive on 10-10 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
B D Parekh	M.D.	ATTENDING PHYSICIAN ☒ / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐	10-12-87

22d. PHYSICIAN'S NAME (OR STAMP)	22e. ADDRESS
B D Parekh M.D.	1908 HARFORD RD, FALLSTON MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	10-13-87	Evergreen Memorial	Finksburg / Carroll / Md.

24. FUNERAL DIRECTOR: NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Eline Funeral Home Reisterstown, Md.	OCT 16 1987	Julia Davidson-Reidel

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

068465 OCT 14 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 29077

1. DECEASED'S NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Gladys	S.	Brown	Oct. 7, 1987	4:15 pm

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 1 DAY HOURS / MIN
Female	White	Dec 5, 1897	89 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
W.Virginia	USA		Harford MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Darlington	3657 Day Rd.	Housewife	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MD	Harford	Darlington	YES ☐ NO XX	3657 Day Rd., 21034

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Samuel		Workman	Etta		Boyce

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	-----	232-48-5214	Marie E.Walters, 3657 Day Rd., Darlington, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a DIABETES MELLITUS & HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO XX	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/7 19 87 to 10/7 19 87 that (I) (we) last saw the deceased alive on 10/7 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dante N. Monakil M.D.	ATTENDING PHYSICIAN XX MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/8/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Dante Monakil M.D.	622 S. Union St., Havre de Grace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10/11/87	End of the Trail	Sam Black Greenbriar W.Va.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Harkins Funeral Home, Inc. 600 Main St., Delta, Pa.	OCT 13 1987	Lisa Davidson-Kimball

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7-84 (VRA 15, 4)

068537 OCT 14 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2970

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Catherine	Middle: V.	Last: BURNS	2a. DATE OF DEATH Month Day Year: Oct. 7 1987	2b. HOUR: 8:00 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: 1 31 03	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 603 Beards Hill Road 21001	
14. FATHER'S NAME First: Isaac	Middle: Wesley	Last: Bayless	15. MOTHER'S MAIDEN NAME First: Martha	Middle:	Last: Ewing
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): N/A	16b. SOCIAL SECURITY NO.: 215-34-0126	17. INFORMANT: Lois Barnhart.	ADDRESS: 848 Ontario St. Havre de Grace, Md. 21078	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Cardiorespiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Renal Failure 2° to Septic Shock — Unk

DUE TO, OR AS A CONSEQUENCE OF (c): Cerebral Infarction 2° to Cerebral Hypoxia — 6 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acquired Pneumonitis / Decubitus Ulcers

19a. DATE OF OPERATION: N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: N/A	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2): Not applicable	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 8-20 19 87 to 10-7 19 87 that (I) (we) last saw the deceased alive on 10-7 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Manuel M[illegible] — DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒		22c. DATE SIGNED: 10/8/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LAZATIN, FIA MUEL	22e. ADDRESS: PO Box 579 S Law St. Aberdeen, MD 21001	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/10/87	23c. NAME OF CEMETERY OR CREMATORY: Wesleyan Chapel	23d. LOCATION CITY OR TOWN: Aberdeen	COUNTY: Harford STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR: OCT 13 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Kinsella	

BP

DHMH - 1650M 1/81 (VRA 15, 4)

870042 OCT 28 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 29102

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached to use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 DECEASED NAME (TYPE OR PRINT) First: Ernest Middle: William Last: Chambers, Sr. Ernest Chambers	2a DATE OF DEATH Month/Day/Year: 10 25 87	2b HOUR: 755 A M			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH Month/Day/Year: March 10, 1908	6 AGE (IN YEARS LAST BIRTHDAY): 79 YRS	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD.		
10 CITY OR TOWN OF DEATH: Havre de Grace	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK DURING MOST OF WORKING LIFE): Inspector Fire Prevention	12b KIND OF BUSINESS OR INDUSTRY: US-govt.Ret.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: Maryland	13b COUNTY: Harford	13c CITY OR TOWN: Edgewood	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET ADDRESS / ZIP CODE: 2217 Perry Avenue 21040	
14 FATHER'S NAME First: Ernest Middle: Lee Last: Chambers	15 MOTHER'S MAIDEN NAME First: Virginia Middle: Evangeline Last: Chewning				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII	16b SOCIAL SECURITY NO: 212-16-0668	17 INFORMANT ADDRESS: Mrs. Helen G. Chambers, 2217 Perry Ave, Edgewood Md. 21040			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cardio pulm arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): CA of lung c metastases, CHF

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Antonino A. Calon, M.D. — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c DATE SIGNED: 10-26-87

22d PHYSICIAN'S NAME (TYPE OR PRINT): ANTONINO A. CALON, M.D. — 22e ADDRESS: 611 S. Union ave., Havre de Grace, Md. 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b DATE: Oct. 28, 1987	23c NAME OF CEMETERY OR CREMATORY: Cokesbury U.M. Cemetery	23d LOCATION CITY OR TOWN: Abingdon COUNTY: Harford STATE: Md.	
24 FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009	25a DATE RECD. BY REGISTRAR: OCT 27 1987	25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

BP_____

DHMH 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 2 9 7 0 1

070342 OCT 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Samuel	MIDDLE	LAST: Caravello	2a. DATE OF DEATH MONTH DAY YEAR: October 26, 1987
2b. HOUR: 9 PM			
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH DAY YEAR: Dec. 1, 1901	6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS
IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Palermo, Sicily	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Belair	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 513 Normandy Lane, 21014	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired pipefitter	12b. KIND OF BUSINESS OR INDUSTRY: Beth.St.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Balto.	13d. INSIDE CITY LIMITS? YES XX NO ☐
13e. STREET ADDRESS / ZIP CODE: 145 S. East Avenue, 21224			
14. FATHER'S NAME FIRST: Thomas	MIDDLE	LAST: Caravello	15. MOTHER'S MAIDEN NAME FIRST: Rose MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213-09-0931	17. INFORMANT ADDRESS: 513 Normandy Lane; Teresa Caravello-Abramowski, 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary edema — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Month

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/5 19 87 to 10/26 19 87 that (I) (we) last saw the deceased alive on 10/8 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/7/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): MICHAEL PUMELL — 22e. ADDRESS: [illegible]

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/30/87	23c. NAME OF CEMETERY OR CREMATORY: Sacred Heart of Jesus	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Joseph N. Zannino, 263 S. Conkling St. 21224		25a. DATE REC'D BY REGISTRAR: OCT 29 1987	25b. REGISTRAR'S SIGNATURE: [signature]

BP_____

DHMH 16 60M 7 84
(VRA 15, 4)

7 1291 NOV 10 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2 9 7 0 3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT): First Joseph; Middle Stanley; Last Chilcoat
2a. DATE OF DEATH: Month 10; Day 31; Year 87
2b. HOUR: 830 A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: ~~Feb~~ 13, 1916 (Month 2; Day 13; Year 16)
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS
If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): LINE FOREMAN
12b. KIND OF BUSINESS OR INDUSTRY: TELEPHONE CO.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford Co.
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: 207 Crocker Drive - Apt. C 207-C 21014

14. FATHER'S NAME: First John; Middle Stanley; Last Chilcoat
15. MOTHER'S MAIDEN NAME: First Marie; Middle Ellen; Last Schmidt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO.: 217-07-8761
17. INFORMANT (NAME) (PHONE) 836-7324 ADDRESS 207-C 207 Crocker Drive - Apt. C Bel Air, Maryland 21014: Mrs. C. Faye Chilcoat

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Vent Tachycardia. Shock. Hypotension — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF (b): Metabolic acidosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): Squamous cell CA Lung with pneumonia 6 months.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-31 19 85 to 10-31 19 87 that (I) (we) last saw the deceased alive on 10-31 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10/31/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): B. PAREKH M.D.
22e. ADDRESS: 1908 HARFORD RD, FALLSTON MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Nov. 3, 1987
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (CITY OR TOWN; COUNTY; STATE): Bel Air; Harford Co.; Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: So. W. Broadway & Williams St, Bel Air, Maryland 21014
25a. DATE REC'D BY REGISTRAR: NOV 03 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landeau

BP_____

DHMH 16 60M 7/84 (VRA 15, 4)

067738 OCT 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG NO 87-27104

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified or consulted.

BP

DHMH - 16 60M 7/84 (VRA 15. 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST: ANNA	MIDDLE: C.	LAST: Cochran	2a DATE OF DEATH MONTH: Oct. DAY: 4, YEAR: 1987	2b HOUR: 2:20 Am/M	
3. SEX: Female	4 RACE: White	5 DATE OF BIRTH MONTH: JAN DAY: 5, YEAR: 1899	6 AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10 CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON Gen. HOSP.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b KIND OF BUSINESS OR INDUSTRY: --		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
MD	Harf.	JOPPA	YES ☐ NO ☒	3407 CLAYTON RD 21085

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Norman	C.	Reed	Leota	--	Sturgil

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no	--	212-74-9138	Helen G.Dorman, 8 Valiant Drive, Abingdon, Md. 21009

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): RENAL FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Hepato-renal syndrome with Ascites.

DUE TO, OR AS A CONSEQUENCE OF (c): Hepatic Tumor.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: C.H.Failure - Ischemic Heart Disease - R(small) pleural effusion

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 9 19 1987 to 10 4 1987 that (I) (we) last saw the deceased alive on 10 14 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
D. L. Pirovolidis MD. PA	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/4/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
D. L. PIROVOLIDIS MD. PA	2112 Bel Air Rd FALLSTON, Md. 21047

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Oct.6,1987	Bel Air Memorial Gardens,	Bel Air Harford Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Howard K.McComas III, Abingdon, Md. 21009	OCT 06 1987	Sylvia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR — REG. NO. 87 29105

070371 M37

1. DECEASED NAME (TYPE OR PRINT): FIRST Elbert MIDDLE Evans LAST Collins, Jr
2a. DATE KNOWN OF DEATH ☑ ESTIMATED ☐ MONTH 10 DAY 28 YEAR 87 — 2b. HOUR 1:40 AM M
3. SEX Male — 4. RACE White — 5. DATE OF BIRTH MONTH 12 DAY 30 YEAR 32 — 6. AGE (IN YEARS IF BIRTHDAY) 54 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.
2c. DATE PRONOUNCED DEAD MONTH 10 DAY 28 YEAR 87 — 2d. HOUR 1:40 AM M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH Fallston Harford MD.
10. CITY OR TOWN OF DEATH Fallston — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General — 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE) Supply Clerk APG — 12b. KIND OF BUSINESS OR INDUSTRY US-govt.
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md — 13b. COUNTY Harford — 13c. CITY OR TOWN Bel Air — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS 1 Wye Oak Dr 21014
14. FATHER'S NAME FIRST Elbert MIDDLE Evans LAST Collins, Sr.
15. MOTHER'S MAIDEN NAME FIRST Hattie MIDDLE Grace LAST Colvin
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes — IF YES, GIVE WAR OR DATES Korea — 16b. SOCIAL SECURITY NO. 465-46-4476
17. INFORMANT ADDRESS William H. Clark, 1 Wye Oak Drive Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) CVA

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE L Rempel M.D. — TITLE (SPECIFY) DSpec. MEDICAL EXAMINER — DATE SIGNED 10-27-87

EXAMINER'S NAME (TYPE OR PRINT) LUIS E RENGEL — ADDRESS 464 Alliance Rd Hrd Co

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — 23b. DATE Oct.30,1987 — 23c. NAME OF CEMETERY OR CREMATORY St.George's Episcopal Cem. Perryman — 23d. LOCATION CITY OR TOWN COUNTY Harford STATE Md.

24. FUNERAL DIRECTOR NAME, ADDRESS Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D BY REGISTRAR OCT 30 1987 — 25b. REGISTRAR'S SIGNATURE Julia Tudor Tindall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

070372

NOV 2 87

REG NO 2907

1. DECEASED NAME (TYPE OR PRINT): Charles Harry Curtin
7a. DATE OF DEATH: OCTOBER 27, 1987
7b. HOUR: 1:30 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 5-19-1916
6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD
10. CITY OR TOWN OF DEATH: ABERDEEN
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3644 CHURCHVILLE ROAD
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RET. USARMY
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MARYLAND
13b. COUNTY: HARFORD
13c. CITY OR TOWN: ABERDEEN
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 3644 CHURCHVILLE RD/21028

14. FATHER'S NAME: HARRY CURTIN
15. MOTHER'S MAIDEN NAME: IRENE DABNEY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES
16b. (IF YES, GIVE WAR OR DATES): WW II
SOCIAL SECURITY NO.: 098-03-6162
17. INFORMANT: PATRICIA A. BOHNENBERG
ADDRESS: BALTO, MD 2 8103 ANALEE DR.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): CONGESTIVE HEART FAILURE — 1-2 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c): CHRONIC LUNG DISEASE — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: C Eck
DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/22/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): CHARLES R. ECK JR.
22e. ADDRESS: 223 W. BEL AIR AVE, ABERDEEN, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): REMOVAL/CREMATION
23b. DATE: 10-30-87
23c. NAME OF CEMETERY OR CREMATORY: R.A. FERRIS & Co
23d. LOCATION CITY OR TOWN, COUNTY, STATE: WEST CHESTER, CHESTER PA
24. FUNERAL DIRECTOR NAME, ADDRESS: TARRING FUNERAL HOME, PA. ABERDEEN MD 21001-3
25a. DATE REC'D BY REGISTRAR: OCT 30 1987
25b. REGISTRAR'S SIGNATURE: Julia Faulkner-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81 (VRA 15, 4)

070626 NOV -3 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 24101

DECEASED NAME (TYPE OR PRINT): First: William | Middle: P | Last: D'Amico

2a DATE OF DEATH: Month Day Year: 10-29-87

2b HOUR: 9:20 A.M.

3 SEX: MALE

4 RACE: WHITE

5 DATE OF BIRTH: Month Day Year: 4 12 05

6 AGE (IN YEARS LAST BIRTHDAY): 82 YRS

If under 1 year: Months / Days

If under 1 hr.: Hours / Min.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD

10 CITY OR TOWN OF DEATH: HAVRE de GRACE

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSPITAL

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) TRANSP. CLERK

12b KIND OF BUSINESS OR INDUSTRY: IBM CORP

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MD

13b COUNTY: HARFORD

13c CITY OR TOWN: HAVRE de GRACE

13d INSIDE CITY LIMITS? YES [ ] NO [X]

13e STREET ADDRESS / ZIP CODE: 1722 OETHS FORD ROAD 21078

14 FATHER'S NAME: First: ANTONIO | Middle | Last: D'AMICO

15 MOTHER'S MAIDEN NAME: First: MARIANINA | Middle | Last: AIELLO

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO: 021092248

17 INFORMANT: MRS. ROSINA R. O'AMICO

ADDRESS: SAME AS #13e

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ANEMIA

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES [ ] NO [X]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET | CITY OR TOWN | COUNTY | STATE

22a I certify that (I) (this hospital) attended the deceased from 10/29 19 87 to 10/29 19 87 that (I) (we) last saw the deceased alive on 10/29 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Dante Monaikil

DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c DATE SIGNED: 10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONAIKIL, MD

22e ADDRESS: Havre de Grace, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION

23b DATE: 30OCTOBER87

23c NAME OF CEMETERY OR CREMATORY: R. A. FERRIS + CO.

23d LOCATION: CITY OR TOWN: WEST CHESTER, | COUNTY | STATE: PA.

24 FUNERAL DIRECTOR: NAME AND ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078

25a DATE REC'D BY REGISTRAR: NOV 2 1987

25b REGISTRAR'S SIGNATURE: Lucia Davidson-Randall

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and registered by the Funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

69342 OCT 22 87 — FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 29108

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial-Transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 25 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) — FIRST / MIDDLE / LAST: RALPH / CARTER / Dettor			2a DATE OF DEATH — MONTH DAY YEAR: 10-18-87	2b HOUR: 10P (34) M
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH — MONTH DAY YEAR: 11 21 04	6 AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD	
10 CITY OR TOWN OF DEATH: FALLSTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN. HOSPITAL	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired	12b KIND OF BUSINESS OR INDUSTRY: Clendenian Bros.	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Harford	Fallston	YES ☐ NO ☒	2212 Larchmont Drive Fallston, Md. 21047

14 FATHER'S NAME — FIRST / MIDDLE / LAST	15 MOTHER'S MAIDEN NAME — FIRST / MIDDLE / LAST	
Robert / / Dettor	Grace / /	

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT — ADDRESS
No		215-03-4594	Mrs. Suzanne Chester 2212 Larchmont Dr. Fallston, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Ventricular fibrillation

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerotic cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c): fracture Right hip - dislocation of right tibia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): aortic aneurysm surgery

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
Oct 13 '87	fracture dislocation right hip	YES ☐ NO ☐	YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
	19	auto accident

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION — STREET / CITY OR TOWN / COUNTY / STATE
	Street	

22a I certify that (I) (this hospital) attended the deceased from October 13 (13) 19 87 to October 18 19 87 that I (we) last saw the deceased alive on October 18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE — DEGREE		22c DATE SIGNED
John N Lee	ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Oct 18 '87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
John N Lee M.D	601 S Union Ave HOG MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION — CITY OR TOWN / COUNTY / STATE
Cremation	10-20-87	Westview Memorial Pk.	Baltimore, Maryland

24 FUNERAL DIRECTOR — NAME / ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
E.F. Lassahn Funeral Home 11750 Belair Rd Kingsville, Md 21087	OCT 21 1987	Barbara Davidson-Randall

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

069352 OCT 22 '87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2707

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH-16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances	MIDDLE: Lorinne	LAST: Denney	2a. DATE OF DEATH MONTH DAY YEAR: October 19, 1987	2b. HOUR: 10:35 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 9 1914	6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Penna.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD	
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY:	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Harford	Havre de Grace	YES [ ] NO [X]	1006 Morrison Blvd. 21078

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Mahlon		Kendall	Helen	E.	Garnes-Fassnacht

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		298-14-8143	Ben G. Denney, Jr. same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Recurrent C.V.A. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO, OR AS A CONSEQUENCE OF (b): A.S.C.V.D. — 2-3 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a: Collaterous Colitis, Aspiration Pneumonitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
[ ]		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		

22a. I certify that (I) (this hospital) attended the deceased from 10/12, 19 87 to 10/19, 19 87, that (I) (we) last saw the deceased alive on 10/19, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
E.C. Loo	M.D.	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	10/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
E.C. Loo, M.D.	Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Oct. 21, 1987	Mt. Erin Cemetery	Havre de Grace Harford Md

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Mitchell Funeral Home Havre de Grace MD	OCT 21 1987	Jackie Davidson-Randall

070728 NOV 4 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 7

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Ellen — MIDDLE: M — LAST: Dietz.

2a. DATE OF DEATH — MONTH DAY YEAR: 10/30/87. — 2b. HOUR: 1:17 AM/PM

3. SEX: FEMALE.

4. RACE: white

5. DATE OF BIRTH — MONTH DAY YEAR: 10 22 14

6. AGE (IN YEARS LAST BIRTHDAY): 73. YRS. — IF UNDER 1 YEAR MONTHS DAYS — IF UNDER 1 DAY HOURS MINS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford. MD

10. CITY OR TOWN OF DEATH: FALLSTON.

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Ret.-Farmer

12b. KIND OF BUSINESS OR INDUSTRY: Self-Employed

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Baltimore — 13c. CITY OR TOWN: — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS / ZIP CODE: 4126 Kahlston Rd. 21236

14. FATHER'S NAME — FIRST: Frank — MIDDLE: — LAST: Eisner

15. MOTHER'S MAIDEN NAME — FIRST: Mamie — MIDDLE: — LAST: Schafferman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO: 213-20-1475

17. INFORMANT — ADDRESS: Joan M. Parsons 1216 Narcissus Ave. 21239

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIO PULMONARY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b): CARDIAC FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c): PNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☒ — 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) — 21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE)

22a. I certify that (I) (this hospital) attended the deceased from 10/29 87 to 10/29 87 that I (we) last saw the deceased alive on 10/30 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante Monaki MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/30/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE MONAKI — 22e. ADDRESS: Havre de Grace, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 11-2-87 — 23c. NAME OF CEMETERY OR CREMATORY: St. Michael Luth. Ch. — 23d. LOCATION CITY OR TOWN, COUNTY, STATE: Baltimore, Maryland

24. FUNERAL DIRECTOR NAME, ADDRESS: Lassahn Funeral Home 7401 Balto

25a. DATE REC'D BY REGISTRAR: NOV 03 1987 — 25b. REGISTRAR'S SIGNATURE: Julia Deardon-Randall

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH 16 60M 7/84 (VRA 15, 4)

5

070113 OCT 29 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2911

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified (marked)

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Mary	MIDDLE: Esther	LAST: Elliott	2a. DATE OF DEATH MONTH DAY YEAR: October 23, 1987	2b. HOUR: 10:30 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: July 7, 1889	6. AGE (IN YEARS LAST BIRTHDAY): 98 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Aberdeen Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co., MD.		
10. CITY OR TOWN OF DEATH: Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Convalescent Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Homemaker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford Co.	13c. CITY OR TOWN: Bel Air	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 126 Hickory Court 21014	
14. FATHER'S NAME FIRST: Harry	MIDDLE	LAST: Crevensten	15. MOTHER'S MAIDEN NAME FIRST: Rida	MIDDLE	LAST: James
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): —	16b. SOCIAL SECURITY NO.: 213-74-3979 215-03-4446-D	17. INFORMANT (Daughter) 838-0276 ADDRESS: 1102-I Iron Bucket Court Mrs. Esther E. Wheeler Bel Air, Maryland 21014		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Artery Disease (Probable) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 - 20 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe Osteoporosis, Depression

19a. DATE OF OPERATION: —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: —	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital) attended the deceased from June, 19 87, to 10/23, 19 87, that (I) (we) last saw the deceased alive on Approx. Oct., 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J.K. Lynch MD — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.K. LYNCH MD — 22e. ADDRESS: 401 FRANKLIN ST. Bel Air, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Entombment	23b. DATE: Oct. 26, 1987	23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Mausoleum	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Baltimore, Maryland	
24. FUNERAL DIRECTOR: Joseph William Foster	ADDRESS: 50 W. Broadway a Williams St. Bel Air, Maryland 21014	25a. DATE REC'D BY REGISTRAR: OCT 26 1987	25b. REGISTRAR'S SIGNATURE	

068060 OCT -8 87

Item 18 1&2, 21a, c, d, e, f, 22a, 6641 7-12-88 per med exam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR STATE REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 2971 2

1 DECEASED NAME (TYPE OR PRINT) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED ☒	2b HOUR
Raymond	A.	Epps	Month 10 Day 2 Year 87	M

3 SEX	4 RACE	5 DATE OF BIRTH Month Day Year	6 AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR Months / Days	IF UNDER 24 HRS. Hours / Min	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
M	N. 2	9-7-48	39 YRS.			10/ 2/19 87	8:25 PM

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH
M.D.	U.S.A.		Harford County, MD

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY
Havre deGrace	Harford Memorial Hospital	Labor	—

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
M.D.	Harford	Harford Co.	YES ☐ NO ☒	605 Dembytown Rd #21085

14 FATHER'S NAME First / Middle / Last	15 MOTHER'S MAIDEN NAME First / Middle / Last
James Jackson	Helen Epps

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
yes	V.C.T.NAM	215-46-9003	Helen Jackson	605 Dembytown Rd #21085

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY

NARCOTIC INTOXICATION

IMMEDIATE CAUSE (a) ~~Arteriosclerotic Cardiovascular Disease~~

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a:

Chronic Alcoholism and Arteriosclerotic Cardiovascular Disease

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
		Subject used drugs

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE
	Home	605 Dembytown Road, Joppa, Harford County, MD

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles P. Kokes M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10/4/87

EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10/8/87	Garrison Forest Cem.	Owenings Md.

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Betts Funeral Home 1129 N. Carolines St.	OCT 6 1987	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE RECORDED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY UNNECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE MD. 21201

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

070625 NOV -3 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 2971

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Iris — MIDDLE: Agnes — LAST: Ferguson
   Iris Agnes Ferguson

2a. DATE OF DEATH — MONTH DAY YEAR: 10 29 87
2b. HOUR: 1708 PM

3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: Feb. 26, 1911
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS
If UNDER 1 YEAR — MONTHS / DAYS
If UNDER 24 HRS — HOURS / MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston Gen Hosp
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: ---

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Edgewood
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 1951 Edgewater Drive 21040

14. FATHER'S NAME — FIRST: John — MIDDLE: — LAST: Wagner
15. MOTHER'S MAIDEN NAME — FIRST: Nellie — MIDDLE: Rae — LAST: Board
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO: 214-36-8607
17. INFORMANT — ADDRESS: Agnes H. Shaffer, 526 Rogers St. Aberdeen, Md. 21001

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Medullary collapse
DUE TO, OR AS A CONSEQUENCE OF (b): Massive Subarachnoid Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS (UNDERLYING OR CONTRIBUTING) CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) ☐
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/27 19 87 to 10/29 19 87 that (I) (we) last saw the deceased alive on 10/29/87 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: J. Douglas Abbott MD
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/29/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. Douglas Abbott MD
22e. ADDRESS: Suite 106 1716 Hartford Rd Fallston Md 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Nov. 2, 1987
23c. NAME OF CEMETERY OR CREMATORY: Holly Hill Memorial Gardens, Middle River
23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Balto. Md.
24a. FUNERAL DIRECTOR — NAME, ADDRESS: Howard K. McComas III, Abingdon, Md. 21009
25a. DATE RECEIVED BY REGISTRAR: NOV 2 1987
25b. REGISTRAR'S SIGNATURE: Virginia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director (page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

069354 OCT 22 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 9 7 1 4

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
NEAL	DOUGLAS	FERGUSON, SR.	OCTOBER 18, 1987	1:42 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
MALE	Black	May 9, 1943	44 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	USA		Harford County MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace	Harford Memorial Hospital	Custodian	US-govt.Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Abingdon	YES ☐ NO ☒	1103 Abingdon Road 21009

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Neal	Harry	Ferguson	Josephine	Florabelle	Thomas

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	--	215-42-5860	Josephine Ferguson Dorman, 1103 Abingdon Rd.	Abingdon,Md. 21009

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arterio-Vascular-Accident

DUE TO, OR AS A CONSEQUENCE OF (b) Severe Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I-a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Joseph Jack, Jr., M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10-19-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Joseph Jack, Jr., M.D,	672 Townecenter Drive, Joppatowne,Md.21085

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	Oct.22,1987	John Wesley U.M.Cemetery, Abingdon	Harford Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	OCT 21 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified before disposition.

BP_____

DHMH 16 60M 7-84
(VRA 15, 4)

3 1

0692 13 OCT 21 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First GLADYS Middle IRENE Lost FERRALL
2a. DATE OF DEATH: Month OCT Day 17 Year 87
2b. HOUR: 10:25 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 12/11/04
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Ohio
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Harford CO. Md.
10. CITY OR TOWN OF DEATH: Forest Hill
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: Harford
13c. CITY OR TOWN: Forest Hill
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 213A Marshall Drive
14. FATHER'S NAME First: William Middle: Lost: Hohler
15. MOTHER'S MAIDEN NAME First: Middle: Lost:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16b. SOCIAL SECURITY NO.: 283-48-1747
17. INFORMANT: Jack Ferrall Address: same (son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
DUE TO, OR AS A CONSEQUENCE OF
(b): ascvd — many years
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus (10 yrs)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this haspital) attended the deceased from _____, 19 80, to 10/17, 19 87, that (I) (we) last saw the deceased alive on 8/17 1987, ond that in (my) (our) opinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: Phyllis K. Pullen MD DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/17/87
22d. PHYSICIAN'S NAME (Type): Phyllis K. Pullen MD
22e. ADDRESS: 2807 Jerusalem Rd., Kingsville, Md 2108

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 10-17-87
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City or Town) (County) (Stote):
24. FUNERAL DIRECTOR: State Anatomy Board ADDRESS: Balto., Md.
25a. RECD BY REGISTRAR DATE: OCT 19 1987
25b. REGISTRAR'S SIGNATURE:

DHMH - 163/72 25M
(VR A15 (4))

070031 OCT 23 87

STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

29716 REG NO

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM, PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: DOROTHY	MIDDLE: MAE	LAST: FREY	2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐	MONTH / DAY / YEAR: 19	2b. HOUR: M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Oct. 16, 1927	6. AGE (IN YEARS, LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	7c. DATE PRONOUNCED DEAD: Oct. 21, 1987	7d. HOUR: 10:05 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD				
10. CITY OR TOWN OF DEATH: Joppa	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 103 Orsburn Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Beautician	12b. KIND OF BUSINESS OR INDUSTRY: Beauty Shop				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Joppa	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 103 Orsburn Drive 21085			
14. FATHER'S NAME: FIRST George	MIDDLE --	LAST Pflugrad	15. MOTHER'S MAIDEN NAME: FIRST Carolyn	MIDDLE --	LAST Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 220-20-6023	17. INFORMANT ADDRESS: Gale Frey, 14 Oregon Ave, New Castle, Del. 19720				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary heart disease
DUE TO, OR AS A CONSEQUENCE OF
(b) A S C V D
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 10-21-87

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St., Havre deGrace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: Oct. 26, 1987	23c. NAME OF CEMETERY OR CREMATORY: R.A. Ferris Crematory	23d. LOCATION CITY OR TOWN: W. Chester	COUNTY: Chester / STATE: Pa.
24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009	25a. DATE RECD. BY REGISTRAR: OCT 27 1987	25b. REGISTRAR'S SIGNATURE		

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

0706 82 NOV -4 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 29117

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): First Rose; Middle A.; Last Galinis
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☑ — Month 10 Day 31 Year 1987
2b. HOUR 10:00 AM
3. SEX: Female
4. RACE: Cauc.
5. DATE OF BIRTH: Month 12 Day 14 Year 09
6. AGE (IN YEARS) (LAST BIRTHDAY): 77 YRS. IF UNDER 1 YR. Months ___ Days ___ IF UNDER 24 HRS. Hours ___ Min. ___
2c. DATE PRONOUNCED DEAD: Month 10 Day 31 Year 1987
2d. HOUR 10:02 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PA
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ xx DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD
10. CITY OR TOWN OF DEATH: FOREST HILL
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): 1413 KAHOE RD.
12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): Seamstress
12b. KIND OF BUSINESS OR INDUSTRY: ClothingCo.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD
13b. COUNTY: Harford
13c. CITY OR TOWN: Forest Hill
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: 1413 Kahoe Rd. 21050

14. FATHER'S NAME: First unknown; Middle; Last
15. MOTHER'S MAIDEN NAME: First Antoinette; Middle; Last Andricks
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 212 10 2507
17. INFORMANT: Mrs. June Potter, Dghtr, same as above — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a:

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: L Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11/2/87

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St. Havre De Grace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11/4/87
23c. NAME OF CEMETERY OR CREMATORY: Oaklawn Cem.
23d. LOCATION CITY OR TOWN; COUNTY; STATE: Balto, Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: 9705 Belair Road SCHIMUNEK FUNERAL HOME, Balto, Md. 21236
25a. DATE REC'D. BY REGISTRAR: NOV 3 1987
25b. REGISTRAR'S SIGNATURE: J. Gordon Landers

07-84 25M BP____ DHMH - 17 (VR A15 ME (5))

071238 NOV-9 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 9 7 1 8
REG. NO.

1 - FOR STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT): First: Helen; Middle: Marie; Last: Gay

2a DATE OF DEATH: KNOWN XX / ESTIMATED ☐ — Month: 10 Day: 29 Year: 1987

2b HOUR: 11a M

3 SEX: F

4 RACE: W

5 DATE OF BIRTH: Month: 6 Day: 23 Year: 09

6 AGE (IN YEARS LAST BIRTHDAY): 78 YRS. IF UNDER 1 YR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN

2c DATE PRONOUNCED DEAD: Month: 10 Day: 29 Year: 1987

2d HOUR: 11a M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10 CITY OR TOWN OF DEATH: Fallston

11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b KIND OF BUSINESS OR INDUSTRY: Home

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MD

13b COUNTY: Harford

13c CITY OR TOWN: Street

13d INSIDE CITY LIMITS? YES ☐ NO XX

13e STREET ADDRESS: 2025 Jerry's Rd. 21154

14 FATHER'S NAME: First: William; Middle: ; Last: Schrieber

15 MOTHER'S MAIDEN NAME: First: Margaret; Middle: ; Last: Wendler

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES):

16b SOCIAL SECURITY NO: 216 05 6648

17 INFORMANT: Richard B. Gay ADDRESS: 2025 Jerry's Rd.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): ASCVD - Coronary heart Dis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY? YES ☐ NO X

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry ☐ and in my opinion death resulted from Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: L Renjel M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 10/30/87

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. ADDRESS: 464 Alliance St. Havre De Grace, MD X

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b DATE: 11/1/1987

23c NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.

23d LOCATION CITY OR TOWN / COUNTY / STATE: Street, Harford, Md.

24 FUNERAL DIRECTOR NAME: M. Gladden Kurtz ADDRESS: Jarrettsville, Md.

25a DATE REC'D BY REGISTRAR: NOV 04 1987

25b REGISTRAR'S SIGNATURE: Gina Davidson-Henderson

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH 17 (VR A15 ME (5))

067736 OCT 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2977

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)	FIRST: John	MIDDLE: W.	LAST: Gillespie, JR.	2a. DATE OF DEATH: MONTH 10 DAY 2 YEAR 87	2b. HOUR: 3:21 P.M.
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: MONTH 4 DAY 25 YEAR 23	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD		
10. CITY OR TOWN OF DEATH: Havre deGrace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Administrator	12b. KIND OF BUSINESS OR INDUSTRY: Dundalk College		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 236 Mount Royal Ave. 21001	
14. FATHER'S NAME: FIRST John MIDDLE William LAST Gillespie, Sr.	15. MOTHER'S MAIDEN NAME: FIRST Kathryn MIDDLE	LAST Sweeney			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korea & V.N	16b. SOCIAL SECURITY NO: 074-12-2606	17. INFORMANT: Helen Gillespie	ADDRESS: same as above	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

(IMMEDIATE CAUSE) (a) Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF: (b) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF: (c) COPD.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Brian T. Jo	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [✓] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/8/87	23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.	23d. LOCATION: CITY OR TOWN Arlington / COUNTY Arlington / STATE Va.	
24. FUNERAL DIRECTOR: NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25a. DATE REC'D BY REGISTRAR: OCT 06 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

U70211 OCT 29 '87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2972

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 2 (Informant's Page) and forward the remaining pages to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic cause, the medical examiner must be notified before disposition.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: ANTHONY	MIDDLE: A.	LAST: GIORDANO	2a. DATE OF DEATH MONTH: 10	DAY: 21	YEAR: 87
2b. HOUR: 7:15 P M					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH: 10	DAY: 31	YEAR: 1902	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS.
IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS. HOURS:	MIN:		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New York	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD		
10. CITY OR TOWN OF DEATH: Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Bel Air Convalesant Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Chemical		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Fallston	YES ☐ NO ☒	1701 Arabian Way 21047

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Pasquale		Giordano	Anna		DelliBovi

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes		153-03-6025	Charmaine Frankowitz	ston, Maryland 1701 Arabian Way, Fall-

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio Pulmonary Arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	Parkinsons disease	YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)	Dementia	YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: History of cerebrovascular accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/8 19 87 to 10/21 19 87 that (I) (we) last saw the deceased alive on 10/15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/21/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID McClure MD	1131 Bel Air Rd Bel Air Md 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	10-24-87	St. Josephs Cemetery	Hackensack, Bergen, NewJersey

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Marzullo Funeral Service	Upperco, MD.	OCT 28 1987	[signature]

070203 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 9 7 2 1

1 - FOR STATE REGISTRAR

REG. NO

1. DECEASED NAME (TYPE OR PRINT) First: Margaret	Middle: J.	Last: Glendenning	2a. DATE OF DEATH: Month 10 Day 26 Year 87	2b. HOUR: 10:28 P.M.
3. SEX: female	4. RACE: white	5. DATE OF BIRTH: Month 07 Day 02 Year 05	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD Co. MD	
10. CITY OR TOWN OF DEATH: FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSP	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Baltimore	Hydes	YES ☐ NO ☒	12942 Harford Road 21082

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
First: Not Known Middle: Last: Voekler	First: Florence Middle: Last: Bell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		212-10-4394	Hydes Margaret F. Crane	Maryland 12942 Harford Rd. 21082

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bradycardia

DUE TO, OR AS A CONSEQUENCE OF (b) End Stage Ischemic Heart

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD, COPD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): COPD, Renal insuff.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/7 19 87 to 10/26 19 87 that (I) (we) last saw the deceased alive on 10/26 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M.D.	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
V.S. NAIR M.D.	2112 Bel air Road. Fallston MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	Oct 30 1987	Parkwood Cemetery	Baltimore Maryland

24. FUNERAL DIRECTOR: NAME / ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc. Baltimore, Maryland	OCT 29 1987	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once!

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

069241 OCT 21 '87

FOR STATE REGISTRAR

Item 18a, 21b, c, d, e, f 10-23-87 dw per med exam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 29122

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT) FIRST: James	MIDDLE: Michael	LAST: Gordon-EL	2a. DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH 10 DAY 12 YEAR 87	2b. HOUR	
3. SEX: MALE	4. RACE: BLACK	5. DATE OF BIRTH MONTH JANUARY DAY 31 YEAR 1948	6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD MONTH 10 DAY 12 YEAR 87	2d. HOUR 8:00 AM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED X / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD		
10. CITY OR TOWN OF DEATH: DARLINGTON	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1215 Holoway Rd. (P.O. BOX 213)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): DISABLED	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: DARLINGTON	13d. INSIDE CITY LIMITS? YES ☐ NO X	13e. STREET ADDRESS: P. O. 213, HOLLOWAY RO, 21034	
14. FATHER'S NAME FIRST: JAMES	MIDDLE: L.	LAST: GORDON	15. MOTHER'S MAIDEN NAME FIRST: HANNAH	MIDDLE	LAST: THOMPSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220 50 1025	17. INFORMANT: MRS. HANNAH GORDON,	ADDRESS: SAME AS #13e	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Narcotic intoxication	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES X NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH 10-12 DAY YEAR 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2): Subject used drugs
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Home	21f. LOCATION STREET: 1215 Holoway Rd. CITY OR TOWN: Darceytown COUNTY: Harford STATE: MD

22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner X.

ACTUAL SIGNATURE: Ann M. Dixon M.D. TITLE (SPECIFY): Deputy Chief MEDICAL EXAMINER DATE SIGNED 10/12/87

EXAMINER'S NAME (TYPE OR PRINT): Ann M. Dixon, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
CREMATION	13OCTOBER87	R. A. FERRIS + COMPANY	WEST CHESTER,		PA.

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
MITCHELL-SMITH FUNERAL HOME,	PA HAVRE de GRACE, MD 21078	OCT 20 1987	

07-84 25M BP 232 DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG NO 87 29123

070370 NOV 3 87

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Christina MIDDLE: Viola LAST: Hanson
2a. DATE OF DEATH — MONTH DAY YEAR: October 26 1987
2b. HOUR: 10:15 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: 12 25 14
6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS. (IF UNDER 1 YEAR — MONTHS DAYS; IF UNDER 24 HRS. — HOURS MIN.)
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Churchville
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 105 Glenville Rd. 21028

14. FATHER'S NAME — FIRST: Richard MIDDLE: LAST: Bruggman
15. MOTHER'S MAIDEN NAME — FIRST: Effie MIDDLE: LAST: Greenland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO: 216-12-5475
17. INFORMANT — ADDRESS: Hall Hanson (husband) same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): PNEUMONIA — 1-2 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c): RENAL FAILURE — 1-2 DAYS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CVA WITH HEMIPARESIS

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE
22a. I certify that (I) (this hospital) attended the deceased from ____ 19____ to ____ 19____ that (I) (we) last saw the deceased alive on ____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE, DEGREE: Eck MD — ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Charles R. Eck, Jr.
22e. ADDRESS: 223 W. Bel Air Ave, Aberdeen, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/29/87
23c. NAME OF CEMETERY OR CREMATORY: Holy Trinity Episcopal
23d. LOCATION — CITY OR TOWN: Churchville COUNTY: Harford STATE: Md.
24. FUNERAL DIRECTOR — NAME, ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399
25a. DATE REC'D BY REGISTRAR: OCT 30 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landress

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH – 16 60M 7/84
(VRA 15, 4)

070440 NOV 287

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 87 29124

1 DECEASED NAME (TYPE OR PRINT): First Lawrence Middle Joseph Last HEINLE
Lawrence J Heinle

2a DATE OF DEATH: Month 10 Day 29 Year 87
2b HOUR: 501 A M

3 SEX: Male
4 RACE: White
5 DATE OF BIRTH: Month March Day 27 Year 1915
6 AGE (IN YEARS LAST BIRTHDAY): 72 YRS
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b CITIZEN OF WHAT COUNTRY?: U.S.A.
8 MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9 BALTIMORE CITY OR COUNTY OF DEATH: Harford Co MD

10 CITY OR TOWN OF DEATH: Fallston
11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Police Officer
12b KIND OF BUSINESS OR INDUSTRY: Baltimore Co., MD

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE: Maryland
13b COUNTY: Baltimore
13c CITY OR TOWN: Kingsville
13d INSIDE CITY LIMITS? YES ☐ NO XX
13e STREET ADDRESS / ZIP CODE: 11197 Sheradale Dr 21087

14 FATHER'S NAME First John Middle Last Heinle
15 MOTHER'S MAIDEN NAME First Louise Middle Last Sraver

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No
(IF YES, GIVE WAR OR DATES): ---------
16b SOCIAL SECURITY NO.: 217-05-8621
17 INFORMANT: Mildred M. Heinle
ADDRESS: 11197 Sheradale Dr. Kingsville, MD. 21087

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Ventricular Dysrhythmia
DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a DATE OF OPERATION
19b CONDITION FOR WHICH OPERATION WAS PERFORMED
20a AUTOPSY? YES ☐ NO XX
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: [signature]
DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑
22c DATE SIGNED: 10/29/87

22d PHYSICIAN'S NAME (TYPE OR PRINT): Joseph Laws MD
22e ADDRESS: Fallston General Hospital

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b DATE: Nov 2, 1987
23c NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d LOCATION: CITY OR TOWN: Baltimore, COUNTY: MD STATE:

24 FUNERAL DIRECTOR NAME: DIPPEL FUNERAL HOME, INC.
ADDRESS: 7110 BELAIR ROAD BALTIMORE, MARYLAND 21206
25a DATE REC'D BY REGISTRAR: OCT 30 1987
25b REGISTRAR'S SIGNATURE: Julia Davidson-Landers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper, Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP____

DHMH 16 60M 7/84
(VRA 15, 4)

070029 OCT 29 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 029725

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Arthur Middle: James Last: Homer				2a. DATE OF DEATH Month Day Year: October 25 1987	2b. HOUR: 3:35 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: Aug. 18, 1915	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Supervisor-Mtn.	12b. KIND OF BUSINESS OR INDUSTRY: Chemical	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Churchville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS / ZIP CODE: 8 Woodside Drive 21028	
14. FATHER'S NAME First: George Middle: W. Last: Homer			15. MOTHER'S MAIDEN NAME First: Fannie Middle: Rosanna Last: Singleton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 213-18-2184	17. INFORMANT: Juanita D. Homer, 8 Woodside Drive, Churchville	ADDRESS: Md. 21028	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a: Severe Pulmonary Empayema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-25 19 87 to 10-25 19 87 that (I) (we) last saw the deceased alive on 10-25 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Danten N. Munakil MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTEN MUNAKIL	22e. ADDRESS: Havre de Grace Md 21078		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Oct. 29, 1987	23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, Bel Air	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Harford Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D BY REGISTRAR: OCT 27 1987	25b. REGISTRAR'S SIGNATURE

068541 OCT 14 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2726

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) First: Kenneth Middle: Gregory Last: Horn (Kenneth G. Horn)		2a. DATE OF DEATH Month Day Year: Oct. 8 1987	2b. HOUR: 7:40 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month Day Year: Dec. 20, 1912	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. If under 1 year: Months / Days; If under 1 hr.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Estimator	12b. KIND OF BUSINESS OR INDUSTRY: Moving-Storage
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Harford	13c. CITY OR TOWN: Abingdon	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: 3805 W. Baker St. 21009			
14. FATHER'S NAME First: Lewis Middle: -- Last: Horn		15. MOTHER'S MAIDEN NAME First: Elizabeth Middle: -- Last: McGovern	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): WWII	16b. SOCIAL SECURITY NO.: 216-07-7838	17. INFORMANT ADDRESS: Mrs. Doris M. Horn, 3805 W. Baker Ave, Abingdon Md. 21009

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): CARDIOGENIC SHOCK

DUE TO, OR AS A CONSEQUENCE OF (c): MYOCARDIAL FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: HYPERTENSION, ARTERIOSCLEROSIS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10-5, 19 87, to 10-8, 19 87, that (I) (we) last saw the deceased alive on 10-8-87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dante N. Monakil MD	DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10/8/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): DANTE N. MONAKIL, MD	22e. ADDRESS: Havre de Grace, Md 21078	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Oct. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY: Cokesbury U.M. Cemetery	23d. LOCATION CITY OR TOWN: Abingdon / COUNTY: Harford / STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009	25a. DATE REC'D. BY REGISTRAR: OCT 13 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 2 9 7 2 7

0688 08 OCT 16 87

DIVISION OF VITAL RECORDS, 201 W PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST	Charlotte B. Hunter	2a DATE OF DEATH MONTH DAY YEAR	October 14 1987
		2b HOUR	4 AM
3 SEX	Female	4 RACE	White
5 DATE OF BIRTH MONTH DAY YEAR	Jan. 20, 1903	6 AGE (IN YEARS LAST BIRTHDAY)	84 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Maryland	7b CITIZEN OF WHAT COUNTRY?	USA
8	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH	Harford MD
10 CITY OR TOWN OF DEATH	Havre de Grace	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A FACILITY, GIVE STREET ADDRESS)	Harford Mem. Hospital
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	Housewife	12b KIND OF BUSINESS OR INDUSTRY	----------
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE	Maryland	13b COUNTY	Cecil
13c CITY OR TOWN	Perryville	13d INSIDE CITY LIMITS?	YES ☒ NO ☐
13e STREET ADDRESS	403 Concord Apts, Perryville, Md. 21903		
14 FATHER'S NAME FIRST MIDDLE LAST	Charles F. Bauer	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	Katherine Pratt
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	----------
16b SOCIAL SECURITY NO.	218-80-4992	17 INFORMANT ADDRESS	Clifford F. Hunter, Jr., Perryville, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	CONGESTIVE HEART FAILURE	
DUE TO, OR AS A CONSEQUENCE OF (c)	Pneumonia	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): √TRUCE

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	YES ☐ NO ☒
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	YES ☐ NO ☐		
21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a I certify that (I) (this hospital) attended the deceased from 10-5 19 87 to 10-14 19 87, that (I) (we) last saw the deceased alive on 10-14 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	Dante U. Monakil M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c DATE SIGNED
22d PHYSICIAN'S NAME (TYPE OR PRINT)	DANTE U. MONAKIL	22e ADDRESS: Havre de Grace, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b DATE	Oct. 16, 1987	23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens
23d LOCATION CITY OR TOWN / COUNTY / STATE	Churchville, Harford, Md.			
24 FUNERAL DIRECTOR (SIGNATURE) ADDRESS	Lee A. Patterson & Son, Perryville, Md.	25a DATE REC'D BY REGISTRAR	OCT 15 1987	25b REGISTRAR'S SIGNATURE: Julia Davidson-Landers

67854 OCT-87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 29728

1a. DECEASED NAME (TYPE OR PRINT): FIRST Reba; MIDDLE Kyle; LAST Ives

2a. DATE OF DEATH: MONTH October; DAY 5; YEAR 1987

2b. HOUR: 9:05 PM

3. SEX: FEMALE

4. RACE: CAUCASIAN

5. DATE OF BIRTH: MONTH 10; DAY 18; YEAR 1914

6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS.: HOURS; MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Maid

12b. KIND OF BUSINESS OR INDUSTRY: Domestic

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES ☐ NO ☑

13e. STREET ADDRESS: 601 Cornell St. 21001

14. FATHER'S NAME: FIRST unk.; LAST

15. MOTHER'S MAIDEN NAME: FIRST unk.; LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

16b. (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 219-07-0226

17. INFORMANT: Sharon Hiltz ADDRESS: 370 Rambling Ridge Rd. 21122

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Ischemic heart disease c MI

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROX. INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) this hospital) attended the deceased from 9/21 19 87 to 9/30 19 87 that (I) (we) last saw the deceased alive on 9/30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.

22b. SIGNATURE: Brian T. Yeo DEGREE: MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): BRIAN T. YEO M.D.

22e. ADDRESS: Union Avenue Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 10-6-87

23c. NAME OF CEMETERY OR CREMATORY: Westview Crem.

23d. LOCATION: CITY OR TOWN Catonsville; COUNTY (Balto); STATE Md

24. FUNERAL DIRECTOR: NAME Raymond C. Fink; ADDRESS Glen Burnie, Md

25a. DATE REC'D BY REGISTRAR: OCT 06 1987

25b. REGISTRAR'S SIGNATURE: Lisa Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 50M 1/81 (VRA 15, 4)

069162 OCT 20 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 2972

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM, PM 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

1. DECEASED NAME (TYPE OR PRINT) FIRST: Martin	MIDDLE: E.	LAST: Jackson, SR.	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒: MONTH 9 DAY 27 YEAR 1987	2b. HOUR M		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: MONTH OCT DAY 12 YEAR 1914	6. AGE (IN YEARS) LAST BIRTHDAY: 72 YRS.	IF UNDER 1 YR. MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 2 YEAR 1987	2d. HOUR 9:30 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD				
10. CITY OR TOWN OF DEATH: Havre deGrace	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 416 Green St.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): (RET) TRUCK DRIVER	12b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS: 416 GREEN STREET 21078			
14. FATHER'S NAME FIRST: NORMAN	MIDDLE	LAST: JACKSON	15. MOTHER'S MAIDEN NAME FIRST: ETTA	MIDDLE: MARIE	LAST: LEAGUE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 217 09 6187	17. INFORMANT ADDRESS: MARTIN E. JACKSON, JR, 4532 WEYMDUTH RD, MEDINA, OH 44256				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Assistant MEDICAL EXAMINER DATE SIGNED: 10/4/87

EXAMINER'S NAME (TYPE OR PRINT): Charles P. Kokes, M.D. ADDRESS: 111 Penn St, Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 8OCTOBER87	23c. NAME OF CEMETERY OR CREMATORY: R. A. FERRIS + COMPANY	23d. LOCATION CITY OR TOWN: WEST CHESTER,	COUNTY / STATE: PA
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078	25a. DATE REC'D. BY REGISTRAR: OCT 13 1987	25b. REGISTRAR'S SIGNATURE: [signature]		

07/84 25M BP

DHMH - 17 (VR A15 ME (5))

69325 OCT 22 87

FOR STATE REGISTRAR 1 -

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2973

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Arvid	MIDDLE: Nunn	LAST: Jackson	2a. DATE OF DEATH MONTH: 10 DAY: 10 YEAR: 87	2b. HOUR: 955 AM
3. SEX: Male	4. RACE: Caucasian	5. DATE OF BIRTH MONTH: 6 DAY: 16 YEAR: 1913	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): New Jersey	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Accounting	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Cecil	Perryville	YES ☑ NO ☐	345 Broad St. Apt 16 21903

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
N/A	N/A

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korean WWII	152-10-8338	Dennis Clower	226 FMAN Elkton MD 21921

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CVA

DUE TO, OR AS A CONSEQUENCE OF (b): COPD / Respiratory insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c): Hyperglycemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 9/26, 19 87, to 10/10, 19 87, that (I) (we) last saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED
T. Lee	M.D.		☑		10/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
T. Lee	Union Med. Clinic

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10-15-87	Quantico	Triangle VA

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.T. Ford Funeral Home Rising Sun MD	OCT 20 1987	Julia Davidson-Randall

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR — REG NO 29131

070150 OCT 29 87

1. DECEASED NAME (TYPE OR PRINT): FIRST Allie; MIDDLE O.; LAST Johnson
2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ MONTH 10 DAY 24 YEAR 1987 — 2b. HOUR M
3. SEX: F — 4. RACE: W — 5. DATE OF BIRTH: MONTH 10 DAY 24 YEAR 35 — 6. AGE (IN YEARS LAST BIRTHDAY): 52 YRS — IF UNDER 1 YR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
2c. DATE PRONOUNCED DEAD: MONTH 10 DAY 24 YEAR 87 — 2d. HOUR 9a M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Aberdeen — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 312 Center Dean St. — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Factory — 12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: MD — 13b. COUNTY: Harford — 13c. CITY OR TOWN: Aberdeen — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 312 Center Dean St. 21001
14. FATHER'S NAME: FIRST James; MIDDLE B.; LAST Joyce — 15. MOTHER'S MAIDEN NAME: FIRST Fannie; MIDDLE E.; LAST Smith
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO.: 223-44-0123 — 17. INFORMANT: Robert (husband) — ADDRESS: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiorespiratory failure
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): COPD ASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: Luis E Renjel M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10/24/87
EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. — ADDRESS: 464 Alliance St. Havre De Grace, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b. DATE: 10/29/87 — 23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris & Co. — 23d. LOCATION CITY OR TOWN: West Chester COUNTY: Chester STATE: Pa.
24. FUNERAL DIRECTOR NAME, ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 — 25a. DATE REC'D BY REGISTRAR: OCT 28 1987 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP
DHMH - 17 (VR A15 ME (5))

070367 NOV -2 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2973 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH-16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Betty	MIDDLE: J	LAST: Jung	2a. DATE OF DEATH MONTH DAY YEAR: Oct 26, 1987	2b. HOUR: 11:53 AM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 9 25 28	6. AGE (IN YEARS LAST BIRTHDAY): 59 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Factory	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Bel Air	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 2312 Creswell Rd. 21014	
14. FATHER'S NAME FIRST: Harry	MIDDLE	LAST: Fisher	15. MOTHER'S MAIDEN NAME FIRST: Edna	MIDDLE	LAST: Lowman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-24-5456	17. INFORMANT ADDRESS: Albert Jung, husband, same as above		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): Acute Anterior Wall Myocardial Infarction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Leticia S Galvez	DEGREE: M.D.	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10/27/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): LETICIA S. GALVEZ, M.D.	22e. ADDRESS: 625 S. UNION AVE. HAVRE DE GRACE MD		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/29/87	23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gardens	23d. LOCATION CITY OR TOWN: Aberdeen	COUNTY: Harford	STATE: Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25a. DATE REC'D. BY REGISTRAR: OCT 30 1987	25b. REGISTRAR'S SIGNATURE: Julia Dawson-Lindsay		

69641 OCT 26 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 29133

DECEASED NAME (TYPE OR PRINT): William H. T. Keen

2a DATE KNOWN OF DEATH ESTIMATED X: 10/16/87 — 2b HOUR: 6D M

3 SEX: M — 4 RACE: W — 5 DATE OF BIRTH: 11 14 41 — 6 AGE (IN YEARS) (LAST BIRTHDAY): 45 YRS — IF UNDER 1 YR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN

2c DATE PRONOUNCED DEAD: 10/16 19 87 — 2d HOUR: 8p M

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland — 7b CITIZEN OF WHAT COUNTRY?: USA — 8 MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ — 9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10 CITY OR TOWN OF DEATH: Aberdeen — 11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 518 S. Parke St. — 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Disabled — 12b KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a STATE: MD — 13b COUNTY: Harford — 13c CITY OR TOWN: Aberdeen, — 13d INSIDE CITY LIMITS? YES XX NO ☐ — 13e STREET ADDRESS: 518 S. Parke St. 21001

14 FATHER'S NAME: William H. Keen — 15 MOTHER'S MAIDEN NAME: Doris Keen

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) — 16b SOCIAL SECURITY NO.: 215 40 0199 — 17 INFORMANT: Doris Keen — ADDRESS: 518 S. Parke St. Aberdeen

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY HEART DISEASE
Conditions, if any, which gave rise to immediate couse (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD.
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a DATE OF OPERATION — 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20 AUTOPSY? YES ☐ NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f LOCATION STREET, CITY OR TOWN, COUNTY, STATE

22a I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural couses ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: Renjel M.D. — TITLE (SPECIFY): Deputy MEDICAL EXAMINER — DATE SIGNED: 10/16/87

EXAMINER'S NAME (TYPE OR PRINT): Luis E. Renjel, M.D. — ADDRESS: 464 Alliance St. HavreDeGrace, MD

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation — 23b DATE: 10/20/87 — 23c NAME OF CEMETERY OR CREMATORY: R. A. Ferris & Co. — 23d LOCATION CITY OR TOWN, COUNTY, STATE: West Chester, Chester Pa.

24 FUNERAL DIRECTOR NAME, ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399 — 25a DATE REC'D BY REGISTRAR: OCT 23 1987 — 25b REGISTRAR'S SIGNATURE: John Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MA 5. FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL, REMOVAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

067943 OCT 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 29734

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, all other traumatic events, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT): First: Lloyd; Middle: J; Last: Joseph Keller
2a. DATE OF DEATH: Month: 10; Day: 5; Year: 87
2b. HOUR: 0550 A.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month: 10; Day: 3; Year: 11
6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Fallston
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Truck Driver
12b. KIND OF BUSINESS OR INDUSTRY: Trucking

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Pennsylvania
13b. COUNTY: Allegheny
13c. CITY OR TOWN: Bethel Park
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 2738 Ohio Street 15102

14. FATHER'S NAME: First: John; Middle: --; Last: Keller
15. MOTHER'S MAIDEN NAME: First: Catherine; Middle: --; Last: Drexsler
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 208-09-2182
17. INFORMANT: Valia J. Keller ADDRESS: 2738 Ohio St. Bethel Park, Pa. 15102

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiogenic Shock
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c): Massive Myocardial
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/5 19 87 to 10/7 19 87, that (I) (we) last saw the deceased alive on 10/5 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD
ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT): V. S. NAIR M.D.
22e. ADDRESS: 2112 Belair Road. Fallston MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct. 8, 1987
23c. NAME OF CEMETERY OR CREMATORY: Queen of Heaven Cemetery
23d. LOCATION: CITY OR TOWN Upper St. Clair COUNTY Washington STATE Pa

24. FUNERAL DIRECTOR (NAME AND ADDRESS): Howard K. McComas III, Abingdon, Md. 21009
H.K. McCOMAS & SON

25a. DATE REC'D. BY REGISTRAR: OCT 07 1987
25b. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

BP 999999

DHMH 16 60M 7/84 (VRA 15, 4)

067900 OCT -9 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 29735

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Dora	Theresa	Kincaid	Oct. 3, 1987	10:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	White	May 21 1935	52 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore, Md.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Harford Co. MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Hydes	2921 Harford Rd.	NursingAsst.	St. Joseph Hos.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Harford	Hydes	YES [ ] NO [X]	2921 Harford Rd. 21082

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Vincent		Brocato	Mary	Frances	Ross

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		218-34-0027	MR. Delbert Kincaid,	2921 Harford Rd. Hydes, Md. 21082

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	respiratory arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	brain tumor	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/16, 1985 to 10/3, 1987, that (I) (we) last saw the deceased alive on 5/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
David S. Dunn	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	10/5/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DAVID S. DUNN	1131 Belair Rd

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Oct. 6, 1987	Dulaney Valley Mem. G.	Timonium	Balto.	Md.

24. FUNERAL DIRECTOR NAME ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087	OCT 07 1987	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 24730

)7063 | NOV -3 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with the fullest medical information available and filed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The certificate must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST Howard MIDDLE Samuel LAST Kinzy
KINZY, HOWARD S

2a. DATE OF DEATH MONTH 10 DAY 29 YEAR 87
2b. HOUR 1226 M

3. SEX MALE
4. RACE WHITE
5. DATE OF BIRTH MONTH 2 DAY 24 YEAR 1919
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD

10. CITY OR TOWN OF DEATH FALLSTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist
12b. KIND OF BUSINESS OR INDUSTRY US-govt.Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland
13b. COUNTY Harford
13c. CITY OR TOWN Joppa
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE 2907 Trout Terrace 21085

14. FATHER'S NAME FIRST Grover MIDDLE Cleveland LAST Kinzy
15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE -- LAST Cartentier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES) WWII
16b. SOCIAL SECURITY NO. 219-05-1865
17. INFORMANT Mrs.Lavora B.Kinzy, 2907 Trout Terrace, Joppa Md. 21085 ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE — ~4 DAYS
DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATE CARCINOMA — ~2 YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 1/ /86 to 10/29 19 87 that (I) (we) last saw the deceased alive on 10/29 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (I) (We) (did) (did not) view the body after death.
22b. SIGNATURE
DEGREE MD ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED 10/29/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P EDWARDS
22e. ADDRESS 3712 BELAIR RD FALLSTON MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b. DATE Nov.2,1987
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park
23d. LOCATION CITY OR TOWN Glen Burnie COUNTY A.A. STATE Md.

24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009
25a. DATE REC'D BY REGISTRAR NOV 2 1987
25b. REGISTRAR'S SIGNATURE

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

170869 NOV -5 87

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2 9737

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	William	H	LANDERS

2a. DATE OF DEATH: MONTH Oct. DAY 31 YEAR 1987 — 2b. HOUR 5:35 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH (MONTH DAY YEAR)	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR (MONTHS / DAYS)	IF UNDER 24 HRS. (HOURS / MIN.)
Male	White	7 13 16	71 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH
West Virginia	U.S.A.		HARFORD MD.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
HAVRE de GRACE	HARFORD Memorial Hospital	Retired Army	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Harford	Aberdeen	YES ☒ NO ☐	117 Farm Road	21001

14. FATHER'S NAME (FIRST MIDDLE LAST)	15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)
Artie H. Landers	Iva May Landers

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
Yes	WW II	191-09-1087	Rosalind Landers, wife,	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Interstitial Pneumonitis of	
DUE TO, OR AS A CONSEQUENCE OF (b)	unknown etiology.	11 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-22, 19 87, to 10-31, 19 87, that (I) (we) last saw the deceased alive on 10-31, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
B Parekh	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10-31-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
B PAREKH MD.	1908 HARFORD RD FALLSTON MD 21047.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/4/87	Bel Air Mem. Gardens	Bel Air / Harford / Md.

24. FUNERAL DIRECTOR NAME, ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399	NOV 4 1987	Julia Davidson Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81 (VRA 15, 4)

068535 OCT 14 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2 9 7 3 8

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other medical examiner must be notified at once.

BP_____

DHMH-16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Thelma	MIDDLE: MARIE	LAST: Leeman	2a. DATE OF DEATH MONTH: 10 DAY: 12 YEAR: 87	2b. HOUR: 4 12 A M	
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: JUNE 10, 1916	6. AGE (IN YEARS LAST BIRTHDAY): 71 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 320 WILSON STREET 21078	
14. FATHER'S NAME FIRST / MIDDLE / LAST: UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST: UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 219 10 0825	17. INFORMANT ADDRESS: JOSEPH J. LEEMAN, 2811 BARTOL AVE, BALTO., MD 21209		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Lung Ca & Respiratory failure — (APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH)

DUE TO, OR AS A CONSEQUENCE OF (b): CHF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 8/15, 19 87 to 10/12, 19 87, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J.J. Lee	DEGREE: M.D. ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10/12/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J.J. Lee	22e. ADDRESS: Union Mem. Clinic	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 12OCTOBER87	23c. NAME OF CEMETERY OR CREMATORY: R. A. FERRIS + COMPANY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: WEST CHESTER, PA	
24. FUNERAL DIRECTOR NAME / ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD 21078		25a. DATE REC'D BY REGISTRAR: OCT 13 1987	25b. REGISTRAR'S SIGNATURE: Trisha Davidson-Randall	

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067746 OCT 87

10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 2977

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper(s). Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances MIDDLE: Isabelle LAST: Long			2a. DATE OF DEATH MONTH DAY YEAR: October 1, 1987	2b. HOUR: 9:30 A.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: January 14, 1905	6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.	
10. CITY OR TOWN OF DEATH: Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 129 Briarcliff Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): School Teacher	12b. KIND OF BUSINESS OR INDUSTRY: Education

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Harford Co.	Bel Air	YES ☐ NO ☒	129 Briarcliff Lane 21014

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Walton / Terrell	Alice / Gorrell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Son) 838-5931	ADDRESS
NO	—	219-18-1674	Mr. Arthur C. Long	2902 Grier Nursery Road Forest Hill, Maryland 21050

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIO PULMONARY ARREST	MINUTS
DUE TO, OR AS A CONSEQUENCE OF (b)	SEVERE MITRAL STENOSIS	YEARS
DUE TO, OR AS A CONSEQUENCE OF (c)	RHEUMATIC HEART DISEASE	YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 5 84 to 9/28 19 87, that (I) (we) last saw the deceased alive on 9/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Barry A. Wohl	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	Oct. 2, 1987

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Barry A. Wohl, M.D.	2003 Rock Spring Road, Forest Hill, Md. 21050

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Oct. 3, 1987	Hampstead Cemetery	Hampstead, Carroll Co. Maryland 21074

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph William Foster Jr.	50 W. Broadway & Williams St. Bel Air, Maryland 21014	OCT 05 1987	

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO 2974

069642 OCT 26 87

1 DECEASED NAME (TYPE OR PRINT): FIRST Gregor MIDDLE A. LAST MacLEOD, SR. (MACLEOD)

2a DATE OF DEATH: MONTH Oct DAY 20 YEAR 1987

2b HOUR 11 30 PM

3 SEX: Male

4 RACE: White

5 DATE OF BIRTH: MONTH Aug. DAY 12 YEAR 1910

6 AGE (IN YEARS LAST BIRTHDAY): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 2 HRS: HOURS, MIN.)

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania

7b CITIZEN OF WHAT COUNTRY?: USA

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10 CITY OR TOWN OF DEATH: Havre de Grace

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Military

12b KIND OF BUSINESS OR INDUSTRY: USA-Ret.

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Md.

13b COUNTY: Harford

13c CITY OR TOWN: Edgewood

13d INSIDE CITY LIMITS? YES [ ] NO [X]

13e STREET ADDRESS / ZIP CODE: 611 Hornbeam 21040

14 FATHER'S NAME: FIRST Alexander MIDDLE -- LAST MacLeod

15 MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE -- LAST Kedar

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): WWII-Korea

16b SOCIAL SECURITY NO.: 183-01-7687

17 INFORMANT: Elizabeth C. MacLeod, 611 Hornbeam Road, ADDRESS Edgewood, Md. 21040

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): COPD Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES [ ] NO [ ]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)

21d INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a I certify that (I) (this hospital) attended the deceased from Oct. 15 19 87 to Oct. 20 19 87 that (I) (we) last saw the deceased alive on Oct. 20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: J.T. Lee DEGREE: M.D ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c DATE SIGNED: 10/28/87

22d PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee

22e ADDRESS: Clinton Med Assoc

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b DATE: Oct. 23, 1987

23c NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

23d LOCATION: CITY OR TOWN Arlington, COUNTY - Arlington, STATE Va.

24 FUNERAL DIRECTOR: NAME, ADDRESS: Howard K. McComas III, Abingdon, Md. 21009

25a DATE REC'D BY REGISTRAR: OCT 23 1987

25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7-84 (VRA 15, 4)

070734 NOV -4 871 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2941

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic agent, the medical examiner must be notified of case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ross (Ross E.) MIDDLE: Edward LAST: Markline (MARKline)				2a. DATE OF DEATH MONTH DAY YEAR: October 31, 1987	2b. HOUR: 9:40 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 22, 1913		6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.	
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Distributor	12b. KIND OF BUSINESS OR INDUSTRY: Bottled Gas
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET ADDRESS: 2022 Park Beach Drive 21001	
14. FATHER'S NAME FIRST: John MIDDLE: William (Slade) LAST: Markline				15. MOTHER'S MAIDEN NAME FIRST: Emma MIDDLE: Mary LAST: Smith	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): --	16b. SOCIAL SECURITY NO.: 218-32-1874		17. INFORMANT: Mrs. Elmira S. Markline, 2022 Park Beach Drive	ADDRESS: Aberdeen, Md. 21001

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Respiratory failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): COPD chr. Bronchitis, Emphysema

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to 10-31 19 87 that (I) (we) last saw the deceased alive on 10-31 19 87 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]	DEGREE: M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10-31-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): B PAREKH M.D.	22e. ADDRESS: 1908 HARFORD RD, FALLSTON MD 21047	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Nov. 3, 1987	23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, Bel Air	23d. LOCATION CITY OR TOWN / COUNTY: Harford / STATE: Md.	
24. FUNERAL DIRECTOR AND ADDRESS: Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR: NOV 03 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landers	

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

-69353 OCT 22 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 29142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH-16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Arless; MIDDLE: W.; LAST: McNutt			2a. DATE OF DEATH — MONTH 10; DAY 18; YEAR 87	2b. HOUR 11:30 PM
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH — MONTH 10; DAY 5; YEAR 31	6. AGE (IN YEARS LAST BIRTHDAY): 56 YRS.	IF UNDER 1 YEAR: MONTHS; DAYS. IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Mississippi	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford Co. MD	
10. CITY OR TOWN OF DEATH: Aberdeen	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 605 Walker St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Army	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Aberdeen	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS: 605 Walker St. 21001
14. FATHER'S NAME — FIRST: Herman; MIDDLE: Francis; LAST: McNutt			15. MOTHER'S MAIDEN NAME — FIRST: Viola; MIDDLE: ; LAST: Step	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Korea	16b. SOCIAL SECURITY NO.: 426-52-8207	17. INFORMANT: Anna E. McNutt	ADDRESS: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Metastatic Carcinoma Pancreas

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY — HOUR A.M. P.M.; MONTH; DAY; YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE	

22a. I certify that (I) (this hospital) attended the deceased from August, 19 87, to October 15, 19 87, that (I) (~~was~~ last saw the deceased alive on October 15, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~was~~) (did not) view the body after death.

22b. SIGNATURE	DEGREE — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 10-19-1987
22d. PHYSICIAN'S NAME (TYPE OR PRINT): MYO THAM	22e. ADDRESS: 9101 FRANKLIN SQ. DR. BALTO, MD 21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10/21/87	23c. NAME OF CEMETERY OR CREMATORY: Harford Mem. Gardens	23d. LOCATION — CITY OR TOWN: Aberdeen; COUNTY: Harford; STATE: Md.	
24. FUNERAL DIRECTOR — NAME AND ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399		25. DATE REC'D BY REGISTRAR: OCT 21 1987	25a. REGISTRAR'S SIGNATURE: Tricia Davidson-Kendall	

068332 OCT 13 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 2 9743

DECEDENT'S NAME (TYPE OR PRINT): FIRST Betty MIDDLE M. LAST Meredith

2a. DATE KNOWN OF DEATH ESTIMATED ☐ MONTH 10 DAY 6 YEAR 19 87 — 2b. HOUR 9:01 A.M. P.M.

3. SEX F — 4. RACE W — 5. DATE OF BIRTH MONTH 1 DAY 28 YEAR 33 — 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS — IF UNDER 1 YR MONTHS DAYS — IF UNDER 24 HRS HOURS MIN

2c. DATE PRONOUNCED DEAD MONTH 10 DAY 6 YEAR 19 87 — 2d. HOUR 9:07 A.M. P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) (PA) USA — 7b. CITIZEN OF WHAT COUNTRY? USA — 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD

10. CITY OR TOWN OF DEATH Havre de Grace — 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial — 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER — 12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md — 13b. COUNTY Harford — 13c. CITY OR TOWN Havre de — 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS 1001 Leslie Rd 21078

14. FATHER'S NAME FIRST CHARLES MIDDLE LAST RUTTER — 15. MOTHER'S MAIDEN NAME FIRST ELLEN MIDDLE LAST ENGLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES) — 16b. SOCIAL SECURITY NO. 220-34-6[illegible]N — 17. INFORMANT Lee - Husband ADDRESS same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? — 20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH — 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 — 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) — 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Luis E Renjel M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 10 6 87

EXAMINER'S NAME (TYPE OR PRINT) LUIS E RENJEL — ADDRESS 464 Alliance St Havre de Grace 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION — 23b. DATE 7OCTOBER87 — 23c. NAME OF CEMETERY OR CREMATORY R. A. FERRIS + COMPANY — 23d. LOCATION CITY OR TOWN WEST CHESTER, COUNTY STATE PA

24. FUNERAL DIRECTOR NAME AND ADDRESS MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078

25a. DATE REC'D BY REGISTRAR OCT 09 1987 — 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07-84 25M BP

DHMH - 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 2974

067798 OCT -7 87

1. DECEASED NAME (TYPE OR PRINT): FIRST THEODORE; MIDDLE ANDREW; LAST MINA, SR
2a. DATE OF DEATH: MONTH 10 DAY 1 YEAR 87
2b. HOUR: 1830 P M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: MONTH June DAY 23, YEAR 1925
6. AGE (IN YEARS LAST BIRTHDAY): 62 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD
10. CITY OR TOWN OF DEATH: FALLSTON
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sr.Tech.Writer
12b. KIND OF BUSINESS OR INDUSTRY: Electronics

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Joppa
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 2522 Chilberry Avenue, Joppa Md 21085

14. FATHER'S NAME: FIRST Walter; MIDDLE Ramond; LAST Mina, Sr.
15. MOTHER'S MAIDEN NAME: FIRST Josephine; MIDDLE Elizabeth; LAST Kozlowski
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes
(IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 218-18-8222
17. INFORMANT: Elizabeth L.Mina, ADDRESS 2522 Chilberry Ave, Joppa Md. 21085

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac Arrest	minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocardial Infarction	Months
DUE TO, OR AS A CONSEQUENCE OF (c)	Atherosclerotic Vascular disease	Years

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: John Meillat
DEGREE: MD
ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]
22c. DATE SIGNED: 10/1/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct.5,1987
23c. NAME OF CEMETERY OR CREMATORY: Holy Rosary's Cemetery
23d. LOCATION: CITY OR TOWN Dundalk; COUNTY Balto; STATE Md.
24. FUNERAL DIRECTOR: NAME AND ADDRESS: Howard K.McComas III, Abingdon, Md. 21009
25a. DATE REC'D BY REGISTRAR: OCT 05 1987
25b. REGISTRAR'S SIGNATURE: Kathleen Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

069658 OCT 26 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2947

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once.

BP_____

DHMH 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Rhoe	Wilson	Mink	October 19, 1987	3:00 A M

3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS
Male	Caucasian	March 18, 1912	75 YRS.		

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.	9. BALTIMORE CITY OR COUNTY OF DEATH
North Carolina	U.S.A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Harford MD

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Jarrettsville	4058 Federal Hill Road	Maintenance	Gas

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Jarrettsville	YES ☐ NO ☒	4058 Federal Hill Road 21084

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Granville	Sherman	Mink	Mattie	Belle	Hash

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No		218-07-0298	Emma M. Mink	same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC LYMPHOCYTIC LEUKEMIA ~2 YR

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/18/85 to 10/19/87 that I (we) last saw the deceased alive on 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.

22b. SIGNATURE	DEGREE		22c. DATE SIGNED
	MD	ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/19/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS	
JOHN P EDWARDS MD	2112 BELAIR RD	FALLSTON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	10/21/87	Bel Air Mem. Gar.	Bel Air	Harford	Md. 21014

24. FUNERAL DIRECTOR NAME	ADDRESS	24a. DATE REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
M. Gladden Kurtz	Jarrettsville, Md.	OCT 21 1987	Meredith Randall

069429 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 2976

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 DECEASED NAME (TYPE OR PRINT) FIRST: Russel	MIDDLE: C	LAST: Morrow	2a DATE OF DEATH MONTH DAY YEAR: 10 20 87	2b HOUR: 2 28 A-M	
3 SEX: M	4 RACE: W	5 DATE OF BIRTH MONTH DAY YEAR: 9 21 34	6 AGE (IN YEARS LAST BIRTHDAY): 53 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 1 DAY HOURS / MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.		
10 CITY OR TOWN OF DEATH: Havre de Grace	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): UNK.	12b KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS
MD.	HARFORD	HAVE DE GRACE	YES ☐ NO ☒	1213 N. STEPNEY RD. 21001

14 FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
CECIL CHARLES MORROW	RUTH E. CULLUM

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
UNK.	215-32-5781	HELEN WASSUM - sister 159 ALLENDALE RD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (c): ARTERIOSCLEROSIS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/18, 19 87, to 10/20, 19 87, that (I) (we) last saw the deceased alive on 10/20, 19 87, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Dante M. Monakil MD	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/20/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
DANTE M. MONAKIL	Havre de Grace, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Removal	10-20-87		

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
State Anatomy Board Balto., Md.	OCT 21 1987	Julia Davidson-Reaves

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

070706 NOV -4 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2 9 7 4 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH – 16 60M 7/84 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST: Martha	MIDDLE: May	LAST: Oliver	2a DATE OF DEATH MONTH DAY YEAR: 10 30 87	2b HOUR: 2:25 PM
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH MONTH DAY YEAR: May 5 1938	6 AGE (IN YEARS LAST BIRTHDAY): 49 YRS	IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Tennessee	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD	
10 CITY OR TOWN OF DEATH: Fallston	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Own Home	12b KIND OF BUSINESS OR INDUSTRY	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Harford	Joppa	YES [ ] NO [X]	117 Fern Drive 21085

14 FATHER'S NAME FIRST / MIDDLE / LAST	15 MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Golden L. Williams	Edith McCurry

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
No	379-34-6167	William Henry Oliver 117 Fern Dr. Joppa, MD 21085

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident (Stroke) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Severe Lung Infection with Sepsis — 6 days
DUE TO, OR AS A CONSEQUENCE OF (c): Bronchitis, Restrictive Lung Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Malnutrition

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 10-23 19 87 to 10-30 19 87 that (I) (we) last saw the deceased alive on 10-30 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Willard P Amos	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10-30-87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
Willard P Amos	2303 Belair Rd, Fallston, MD 21047

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	11/3/87	Higgins Chapel	Erwin Unicoi Tenn.

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222	NOV 03 1987	Julia Davidson-Randall

068903 OCT 19 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2978

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 50M 1/81 (VRA 15, 4)

1 DECEASED NAME (TYPE OR PRINT) FIRST: Raymond	MIDDLE: A	LAST: Pinion	2a DATE OF DEATH MONTH DAY YEAR: Oct. 12 1987	2b HOUR: 8:01 P M	
3 SEX: male	4 RACE: Black	5 DATE OF BIRTH MONTH DAY YEAR: 3 24 1884	6 AGE (IN YEARS LAST BIRTHDAY): 103 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD		
10 CITY OR TOWN OF DEATH: HAVRE de GRACE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): HARFORD MEMORIAL HOSP	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer	12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE: Maryland	13b COUNTY: Harford	13c CITY OR TOWN: Havre deGrace	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET ADDRESS: 109 George Ct. 21078	
14 FATHER'S NAME FIRST: Lewis	MIDDLE	LAST: Pinion	15 MOTHER'S MAIDEN NAME FIRST: Carrie	MIDDLE	LAST: Collins
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.: 220-22-5569	17 INFORMANT: Doris V. Durbin	ADDRESS: 109-C Hamilton Place Aberdeen, Md. 21001	

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiorenal failure	?
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriolonephrosclerosis	> One year
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized A.S.C.V.D.	5 years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a

Uremia.

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE

22a I certify that (I) (this hospital) attended the deceased from 10/12, 19 87 to 10/12, 19 87 that (I) (we) last saw the deceased alive on 10/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Edward C Loo, M.D.	DEGREE: M.D. ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c DATE SIGNED: 10/13/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT): Edward C. Loo, M.D.	22e ADDRESS: Havre de Grace, Md. 21078		

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b DATE: 10/15/87	23c NAME OF CEMETERY OR CREMATORY: Union United Cemetery	23d LOCATION CITY OR TOWN: Aberdeen	COUNTY: Harford STATE: Md.
24 FUNERAL DIRECTOR NAME, ADDRESS: Tarring Funeral Home, PA, Aberdeen, Md. 21001-3399	25a DATE REC'D BY REGISTRAR: OCT 16 1987	25b REGISTRAR'S SIGNATURE: Julia Dickson Lankford		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO 070369 NOV 87

1. DECEASED NAME (TYPE OR PRINT): First Everett Middle D. Last Pyle
2a. DATE OF DEATH: Month October Day 27 Year 1987
2b. HOUR: 11 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Month August Day 13 Year 1908
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS
If under 1 year: Months / Days
If under 1 hr.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Pennsylvania
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Bookkeeper
12b. KIND OF BUSINESS OR INDUSTRY: Packing Company

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Whiteford
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE: 2635 Whiteford Road - 21160

14. FATHER'S NAME: First Edward Middle E. Last Pyle
15. MOTHER'S MAIDEN NAME: First Bertha Middle Last Duphorn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): ----------
16b. SOCIAL SECURITY NO.: 705-10-8951
17. INFORMANT: Margaret P. Williams ADDRESS: 324 South Union Avenue Havre de Grace, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cardio-genic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 dy
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Vascular Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (c): Abscess Leg Erysipelas

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Gastro-intestinal Bleed

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):
21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):
21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-12 19 87 to 10-27 19 87 that (I) (we) last saw the deceased alive on 10-27 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: Irwin L. Wachsman DEGREE: MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 10/28/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Irwin L. Wachsman
22e. ADDRESS: S. Union Ave; Havre de Grace MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 10/31/87
23c. NAME OF CEMETERY OR CREMATORY: Slate Ridge Cemetery
23d. LOCATION: CITY OR TOWN: Peachbottom Twp. / COUNTY: York / STATE: PA
24. FUNERAL DIRECTOR: NAME / ADDRESS: Harkins Funeral Home, Inc. 600 Main St. Delta, PA
25a. DATE REC'D BY REGISTRAR: OCT 30 1987
25b. REGISTRAR'S SIGNATURE: Julia Dashiell Lindsay

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

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070 52 OCT 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 29750

1. DECEASED NAME (TYPE OR PRINT): FIRST Virgil; MIDDLE; LAST Ross

2a. DATE OF DEATH: MONTH October DAY 24 YEAR 1987

2b. HOUR 2:50 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH 10 DAY 6 YEAR 20

6. AGE (IN YEARS LAST BIRTHDAY): 67 YRS. IF UNDER 1 YEAR: MONTHS; DAYS. IF UNDER 24 HRS: HOURS; MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD.

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Mem. Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Army

12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Aberdeen

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS / ZIP CODE: 808 Matthews Ave. 21001

14. FATHER'S NAME: FIRST John; MIDDLE; LAST Ross

15. MOTHER'S MAIDEN NAME: FIRST Alta; MIDDLE Mae; LAST Selvage

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes (IF YES, GIVE WAR OR DATES): Vietnam WWII, Korea

16b. SOCIAL SECURITY NO.: 030-22-6338

17. INFORMANT: Edith Ross S.A.A (ADDRESS)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhagic Shock
DUE TO, OR AS A CONSEQUENCE OF (b): Gastrointestinal Bleeding
DUE TO, OR AS A CONSEQUENCE OF (c): Cirrhosis of Liver
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f. LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a. I certify that (I) (this hospital) attended the deceased from 10-19-87 to 10-24-87, that (I) (we) last saw the deceased alive on 10-24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Dentin N. Munchhoff DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dentin N. Munchhoff

22e. ADDRESS: Forest Grove, Md 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 10/28/87

23c. NAME OF CEMETERY OR CREMATORY: R. A. Ferris & Co.

23d. LOCATION: CITY OR TOWN West Chester; COUNTY Chester; STATE Pa.

24. FUNERAL DIRECTOR: NAME, ADDRESS: Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399

25a. DATE REC'D BY REGISTRAR: OCT 28 1987

25b. REGISTRAR'S SIGNATURE:

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

069570 OCT 23 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO 29751

1 DECEASED NAME (TYPE OR PRINT): FIRST LEONARD MIDDLE John LAST SCHENNING.

2a DATE OF DEATH: MONTH 10 DAY 19 YEAR 87

2b HOUR: 900 A M

3 SEX: MALE

4 RACE: white

5 DATE OF BIRTH: MONTH 12 DAY 27 YEAR 25

6 AGE (IN YEARS LAST BIRTHDAY): 61 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b CITIZEN OF WHAT COUNTRY? USA

8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD

10 CITY OR TOWN OF DEATH: FALLSTON

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSP.

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer

12b KIND OF BUSINESS OR INDUSTRY: Dairy

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Maryland

13b COUNTY: Harford

13c CITY OR TOWN: Bel Air

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE: 2816 Calvary Road 21014

14 FATHER'S NAME: FIRST Henry MIDDLE (nmn) LAST Schenning

15 MOTHER'S MAIDEN NAME: FIRST Barbara MIDDLE Anna LAST Vasold

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no (IF YES, GIVE WAR OR DATES): —

16b SOCIAL SECURITY NO: 215-36-7938

17 INFORMANT: John E. Schenning, ADDRESS 2816 Calvary Road, BelAir, Md 21014

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): AdenoCA RtLung with Bone-lymphnode mets — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months.

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES ☐ NO ☐

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET CITY OR TOWN COUNTY STATE

22a **I certify** that (I) (this hospital) attended the deceased from 10-6 19 87 to 10-19 19 87, that (I) (we) last saw the deceased alive on 10-18 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: B Pareich MD

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c DATE SIGNED: 10-19-87

22d PHYSICIAN'S NAME (TYPE OR PRINT): B. PAREICH MD.

22e ADDRESS: 1908 HARFORD RD. FALLSTON MD 21047

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b DATE: Oct. 22, 1987

23c NAME OF CEMETERY OR CREMATORY: Sacred Heart of Jesus Cemetery

23d LOCATION: CITY OR TOWN Baltimore COUNTY Balto STATE Md.

24 FUNERAL DIRECTOR: NAME AND ADDRESS: Howard K. McComas III, Abingdon, Md. 21009

25a DATE REC'D BY REGISTRAR: OCT 22 1987

25b REGISTRAR'S SIGNATURE: Julia Davidson-Mansfield

IMPORTANT: If item 21 is marked or item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2752

068459 OCT 13 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: H. HOWARD SCHWANDTNER				2a DATE OF DEATH MONTH DAY YEAR: 10-9-87	2b HOUR: 140 AM
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH MONTH DAY YEAR: Nov. 6, 1916	6 AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Balto. Co.Md.	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD		
10 CITY OR TOWN OF DEATH: FALLSTON	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GENERAL HOSPITAL	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter	12b KIND OF BUSINESS OR INDUSTRY: Self-Employed		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Baltimore	Perry Hall	YES ☐ NO ☒	4009 Schroeder Ave. 21128

14 FATHER'S NAME FIRST / MIDDLE / LAST	15 MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Herman Schwandtner	Elizabeth Byer

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
no	216-10-2370	Mrs. Joyce Brewer, Baldwin, Md. 21013 2532 Greene Rd.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a) CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE

DUE TO, OR AS A CONSEQUENCE OF (c) MYELOSCLEROSIS

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a: METASTATIC CARCINOMA OF PROSTATE Gland

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 9/30 19 87 to 10/9 19 87 that (I) (we) last saw the deceased alive on 10/9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE, DEGREE	22c DATE SIGNED
Dante Monakil ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	10/9/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
DANTE MONAKIL	Havre de Grace, Md 21078

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Burial	10-12-1987	Highview Mem. Gardens	Fallston Harford Md.

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Kingsville, Md. 21087	OCT 13 1987	Julia Davidson-Reynolds

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top two papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP_____

DHMH 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

REG. NO. 070343 OCT 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper and page 2 and forward page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Bessie	MIDDLE: T.	LAST: Scott	2a. DATE OF DEATH MONTH DAY YEAR: 10 21 87	2b. HOUR: 5:00 AM
3. SEX: Female	4. RACE: BLACK	5. DATE OF BIRTH MONTH DAY YEAR: Nov. 19, 1900	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 1 HR.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD	
10. CITY OR TOWN OF DEATH: HAVRE de GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CITIZENS NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): COOK	12b. KIND OF BUSINESS OR INDUSTRY: PRIVATE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET ADDRESS / ZIP CODE: 4054 GRAVEHILL RD. 21078
14. FATHER'S NAME FIRST: SAMUEL	MIDDLE	LAST: TURNER	15. MOTHER'S MAIDEN NAME FIRST: CLARA	MIDDLE	LAST: LEE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 220-38-3672	17. INFORMANT: Joyce Brown	ADDRESS: 153 Keystone RD. Chester PA.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: old Cerebrovascular accident

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) this hospital attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sang W. Kim M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☑ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 10/21/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): SANG W. KIM | 22e. ADDRESS: 308 S. Union Ave. Havre de Grace MD 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 10-26-87	23c. NAME OF CEMETERY OR CREMATORY: Gravehill Cemetery	23d. LOCATION CITY OR TOWN: Havredegrace COUNTY: Harford STATE: MD 21078	
24. FUNERAL DIRECTOR NAME: Lee Funeral Home	ADDRESS: 592 Union Ave. Havre de Grace MD	25a. DATE REC'D BY REGISTRAR: OCT 28 1987	25b. REGISTRAR'S SIGNATURE: Lia Davidson-Rondella	

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 068775 OCT 6 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3 (CERTAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH 17 (VR A15 ME (5))

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO 2975

DECEASED NAME (TYPE OR PRINT) FIRST: Elizabeth	MIDDLE: Ann	LAST: Sherman	2a DATE OF DEATH KNOWN X / ESTIMATED ☐ MONTH DAY YEAR: 10/12/19 87	2b HOUR: M
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH MONTH DAY YEAR: May 18,1952	6 AGE (IN YEARS LAST BIRTHDAY): 35 YRS. IF UNDER 1 YR. MONTHS DATE; IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD MONTH DAY YEAR: 10/12/19 87	2d HOUR: 5:15 a M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD		
10 CITY OR TOWN OF DEATH: Bel Air	11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2519 Bradfield Ave.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Secretary	12b KIND OF BUSINESS OR INDUSTRY: Automotive		

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO X	13e STREET ADDRESS
Maryland	Harford	Bel Air		2519 Bradfield Avenue 21014

14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
William	Alexander	Gibson	Nancy	Erma	Edwards

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
no	--	213-58-3391	William A. Gibson, 2017 Roberson Road, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun Wound of Chest & Abdomen

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES X NO ☐

21a EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
	XX 10/ 12/ 87	subject shot

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
	home	2519 Bradfield Ave., Bel Air, Harford, Md.

22a I certify that I took charge of the remains described above, held an Autopsy X, Inspection ☐, Inquiry ☐ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide X, Undetermined manner ☐.

ACTUAL SIGNATURE: Ann M. Dixon M.D. TITLE (SPECIFY): Deputy Chief MEDICAL EXAMINER DATE SIGNED: 10/12/87

EXAMINER'S NAME (TYPE OR PRINT): Ann M. Dixon, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Oct.15,1987	Bel Air Memorial Gardens,	Bel Air	Harford	Md.

24 FUNERAL DIRECTOR NAME ADDRESS	25a DATE REC'D. BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	OCT 15 1987	Julia Davidson-Randall

068774 OCT 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 2975

DECEASED NAME (TYPE OR PRINT): First: Stevenson | Middle: Thomas | Last: Sherman

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month/Day/Year: 10/12/19 87 | 2b. HOUR: M

3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Month/Day/Year: July 1,1953 | 6. AGE (IN YEARS) (LAST BIRTHDAY): 34 YRS | IF UNDER 1 YR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN

2c. DATE PRONOUNCED DEAD: Month/Day/Year: 10/ 12/ 87 | 2d. HOUR: 6:15 a M

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD

10. CITY OR TOWN OF DEATH: Bel Air | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2519 Bradfield Ave. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Mechanic | 12b. KIND OF BUSINESS OR INDUSTRY: Auto

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland | 13b. COUNTY: Harford | 13c. CITY OR TOWN: Bel Air | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET ADDRESS: Md. 21014 2519 Bradfield Avenue, BelAir

14. FATHER'S NAME: First: Stevenson | Middle: Donald | Last: Sherman

15. MOTHER'S MAIDEN NAME: First: Phyllis | Middle: Irene | Last: Hatcher

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): --

16b. SOCIAL SECURITY NO: 213-58-3755

17. INFORMANT: Stevenson Donald Sherman, ADDRESS: 2123 Roberson Rd, BelAir, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun Wound of Chest & Abdomen — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a.

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?:

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR: XX 10/12/1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): subject shot

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): home

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE: 2519 Bradfield Ave., Bel Air, Harford, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ] and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy Chief MEDICAL EXAMINER DATE SIGNED: 10/12/87

EXAMINER'S NAME (TYPE OR PRINT): Ann M. Dixon, M.D. ADDRESS: 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: Oct.15,1987 | 23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Bel Air Harford Md.

24. FUNERAL DIRECTOR NAME / ADDRESS: Howard K. McComas III, Abingdon, Md. 21009

25a. DATE REC'D. BY REGISTRAR: OCT 15 1987 | 25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3. A GOLD BORDER WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84 25M BP

DHMH 17 (VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 2 9 756

170628 NOV -3 87

1. DECEASED NAME (TYPE OR PRINT) — FIRST: HUMAN; MIDDLE: H.; LAST: SLAYBAUGH
2a. DATE OF DEATH — MONTH: Oct; DAY: 28; YEAR: 1987
2b. HOUR: 5:52 P.M.
3. SEX: Male
4. RACE: CAUCASION
5. DATE OF BIRTH — MONTH: 3; DAY: 23; YEAR: 1908
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS.
IF UNDER 1 YEAR — MONTHS: ; DAYS: ; IF UNDER 24 HRS. — HOURS: ; MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): PENNSYLVANIA
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD
10. CITY OR TOWN OF DEATH: Havre de Grace
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired
12b. KIND OF BUSINESS OR INDUSTRY: US Govt
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Cecil
13c. CITY OR TOWN: Rising Sun
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS / ZIP CODE: Box 113, Ye Louise Ct 21911
14. FATHER'S NAME — FIRST: Harry; MIDDLE: ; LAST: Slaybaugh
15. MOTHER'S MAIDEN NAME — FIRST: Mary Alice; MIDDLE: LUALTER; LAST:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO
(IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 207-07-9717
17. INFORMANT — ADDRESS: PO B113
MARIAN Slaybaugh Rising Sun MD 21911

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:
DUE TO, OR AS A CONSEQUENCE OF (b): Acute MI
DUE TO, OR AS A CONSEQUENCE OF (c): AS VD
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.a

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET; CITY OR TOWN; COUNTY; STATE
22a. I certify that (I) (this hospital) attended the deceased from 10-28 19 87 to 10/28 19 87 that (I) (we) last saw the deceased alive on 10/28 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: T Lee MD
DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10/28/87
22d. PHYSICIAN'S NAME (TYPED OR PRINTED): T Lee
OFFICE ADDRESS: Union Med. Clinic

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11-1-87
23c. NAME OF CEMETERY OR CREMATORY: West Nottingham
23d. LOCATION — CITY OR TOWN: Colora; COUNTY: Cecil; STATE: MD
24. FUNERAL DIRECTOR — NAME: Foard Funeral Home; ADDRESS: Rising Sun, Md.
25a. DATE REC'D BY REGISTRAR: NOV 2 1987
25b. REGISTRAR'S SIGNATURE: Julie Davidson-Landers

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, disposition.

IMPORTANT: If item 21 is marked or item 18 shows injury, or other traumatic event, no medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

069466 OCT 23 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT): FIRST Nelson MIDDLE M. LAST Snouffer — Nelson Snouffer

2a. DATE OF DEATH: MONTH 10 DAY 19 YEAR 87 — 2b. HOUR 4:15 pm M

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: MONTH Jan. DAY 22 YEAR 1898

6. AGE (IN YEARS LAST BIRTHDAY): 89 YRS — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD

10. CITY OR TOWN OF DEATH: Belair

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Belair Convalescent Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Builder

12b. KIND OF BUSINESS OR INDUSTRY: Construction

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Harford

13c. CITY OR TOWN: Belair

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE: 410 MacPhail Rd., 21014

14. FATHER'S NAME: FIRST Oscar MIDDLE Lee LAST Snouffer

15. MOTHER'S MAIDEN NAME: FIRST Ada MIDDLE Rebecca LAST Clark

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES): -

16b. SOCIAL SECURITY NO.: 213-09-7522

17. INFORMANT ADDRESS: Evelyn L. Miller, 118 Northwood Dr., 21093

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio pulm Arrest

DUE TO, OR AS A CONSEQUENCE OF (b): Bowel Obstruction

DUE TO, OR AS A CONSEQUENCE OF (c): Squamous Parkeratosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Malnutrition

19a. DATE OF OPERATION: -

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: -

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ — N/A

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — N/A

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (I) this hospital) attended the deceased from Oct 8 19 85 to 10-19 19 87 that (I) (we) last saw the deceased alive on Oct 19 87 and that to (my) (our) opinion death occurred on the date and hour and from the causes stated. (I) (we) did not view the body after death.

22b. SIGNATURE: Robert A. Duncan MD

DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Robert A. Duncan

22e. ADDRESS: 1131 Belair Rd Belair, MD 21014

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation

23b. DATE: 10/22/87

23c. NAME OF CEMETERY OR CREMATORY: Westview Crematory

23d. LOCATION: CITY OR TOWN Catonsville, COUNTY Balto., STATE Md.

24. FUNERAL DIRECTOR (NAME AND ADDRESS): J. E. Lowell Lemmon, 10 W. Padonia Rd.

25a. DATE REC'D BY REGISTRAR: OCT 22 1987

069458 OCT 23 87 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2957

REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	KATHLEEN N. SOMERS		2a. DATE OF DEATH MONTH DAY YEAR	10 5 87	2b. HOUR 11:45 PM
3. SEX	F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR	3 22 24	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	GEORGIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. BALTIMORE CITY OR COUNTY OF DEATH XXXXXXXXXXXXXXX. HARFORD MD.
10. CITY OR TOWN OF DEATH	PYLESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	4818 CLERMONT MILL RD.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	ASSEMBLY WKER 12b. KIND OF BUSINESS OR INDUSTRY WESTERN ELEC
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD.	13b. COUNTY HARFORD	13c. CITY OR TOWN PYLESVILLE	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS 4818 CLERMONT MILL RD. 21132
14. FATHER'S NAME FIRST / MIDDLE / LAST	MOLLIE GROOVER		15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	NELL GERTRUDE SIMS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	253-20-7039	17. INFORMANT ADDRESS MARTHA GUPTOM- sister - s/a

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9/25 19 87 to 10/8 19 87 that (I) (we) last saw the deceased alive on 19 87 and that (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE [signature] DEGREE MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED 10/11/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN P. EDWARDS 22e. ADDRESS 3112 BELAIR RD FALLSTON MD 21047

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE	
Removal	10-6-87			
24. FUNERAL DIRECTOR NAME / ADDRESS	State Anatomy Board Balto., Md.	25a. DATE REC'D BY REGISTRAR	OCT 21 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Landers

BP_____

DHMH - 16 50M 4/82
(VRA 15, 4)

0 7 0 7 3 8 NOV -4 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2977

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH-16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Floyd	MIDDLE: W.	LAST: Sparks	2a. DATE OF DEATH MONTH DAY YEAR: Oct. 31, 1987	2b. HOUR: 5:1 M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: Oct. 21, 1937	6. AGE (IN YEARS LAST BIRTHDAY): 50 YRS	IF UNDER 1 YEAR: MONTHS DAYS	IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SERVICEMAN	12b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Harford	13c. CITY OR TOWN: Pylesville	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: #10 old Pylesville Rd. 21132	
14. FATHER'S NAME FIRST: John	MIDDLE: W.	LAST: Sparks	15. MOTHER'S MAIDEN NAME FIRST: Mary	MIDDLE: B.	LAST: Cochran
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 218-34-2031	17. INFORMANT ADDRESS: PEGGY TCHORYK, CLAYTON, NC. 27520			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cryptococcal Meningitis and septicemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Adult Immunodeficiency Syndrome

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 10-26, 1987 to 10-31, 1987 that (I) (we) last saw the deceased alive on 10-31 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R.S. Ackhart

DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 31 Oct 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): R.S. Ackhart, MD.

22e. ADDRESS: 119 W. High Street Elkton, MD 21921

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Nov.4,1987	23c. NAME OF CEMETERY OR CREMATORY: Garrison Forest Vets	23d. LOCATION CITY OR TOWN COUNTY STATE: Owings Mills Baltimore MD
24. FUNERAL DIRECTOR NAME ADDRESS: Harkins Funeral Home, Inc., Delta, PA 17314		25a. DATE REC'D. BY REGISTRAR: 11-3-87	25b. REGISTRAR'S SIGNATURE

8

069527 OCT 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO

1 DECEASED NAME (TYPE OR PRINT): FIRST Gertrude; MIDDLE Anna; LAST STRICKER

2a DATE OF DEATH: MONTH Oct. 19, 1987 | DAY 10 | YEAR 19 87

2b HOUR 1:20 A.M.

3 SEX: Female

4 RACE: White

5 DATE OF BIRTH: MONTH 6 | DAY 12 | YEAR 1916

6 AGE (IN YEARS LAST BIRTHDAY): 71 (71) YRS

IF UNDER 1 YEAR: MONTHS | DAYS

IF UNDER 1 HR.: HOURS | MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Baltimore Maryland

7b CITIZEN OF WHAT COUNTRY?: U.S.A.

8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH: Fallston (HARFORD CO.) MD

10 CITY OR TOWN OF DEATH: Fallston

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife

12b KIND OF BUSINESS OR INDUSTRY: Homemaker

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: Maryland

13b COUNTY: Harford Co.

13c CITY OR TOWN: Forest Hill 21050

13d INSIDE CITY LIMITS? YES ☐ NO ☒

13e STREET ADDRESS / ZIP CODE: 2907 Smithson Drive 21050

14 FATHER'S NAME: FIRST Edward; MIDDLE; LAST Auer

15 MOTHER'S MAIDEN NAME: FIRST Minnie; MIDDLE; LAST Schelhaus

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

16b (IF YES, GIVE WAR OR DATES): —

16b SOCIAL SECURITY NO: 214-01-7218

17 INFORMANT (Daughter) 838-1154 ADDRESS: Mrs. Claire A. Hull 2907 Smithson Drive Forest Hill, Maryland 21050

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): intracranial hypertension — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 | 19 | 87

DUE TO, OR AS A CONSEQUENCE OF (b): diffuse intracerebral metastases, malignant — 10 | 16 | 87

DUE TO, OR AS A CONSEQUENCE OF (c): Recent Colon Malignancy

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ulcers, syncope

19a DATE OF OPERATION:

19b CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a AUTOPSY? YES ☐ NO ☒

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2):

21d INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.):

21f LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a I certify that (I) (this hospital) attended the deceased from 10 | 16 | 87 19____ to 10 | 19 | 87 19____ that (I) (we) last saw the deceased alive on 10 | 19 | 87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Patricia A. Weber — DEGREE: M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c DATE SIGNED: 10 | 19 | 87

22d PHYSICIAN'S NAME (TYPE OR PRINT): WEBER M.D.

22e ADDRESS: Fallston General Hospital

23a BURIAL, CREMATION, REMOVAL (SPECIFY): Entombment

23b DATE: Oct. 21, 1987

23c NAME OF CEMETERY OR CREMATORY: Deltona Memorial Gardens Mausoleum

23d LOCATION: CITY OR TOWN: Deltona; COUNTY; STATE: Florida

24 FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: 50 W. Broadway & Williams St Bel Air, Maryland 21014

25a DATE REC'D BY REGISTRAR: OCT 20 1987

25b REGISTRAR'S SIGNATURE: Irene Davidson-Hendella

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

068333 OCT 13 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 2 9761

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Henry	Middle: J.	Last: Sturm	2a. DATE OF DEATH Month: October Day: 7 Year: 1987	2b. HOUR 1132 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH Month: Jan Day: 22 Year: 1901	6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS.	UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD		
10. CITY OR TOWN OF DEATH: Havre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Agriculture		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE: Maryland	13b. COUNTY: Harford	13c. CITY OR TOWN: Darlington	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS: 3625 Dublin Rd. 21034	
14. FATHER'S NAME First: Samuel	Middle: C.	Last: Sturm	15. MOTHER'S MAIDEN NAME First: Dora	Middle:	Last: Harris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): ------	16b. SOCIAL SECURITY NO: 235-50-7876	17. INFORMANT: Henry J. Sturm	ADDRESS: 3625 Dublin Rd., Darlington MD, 21034	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardiac arrest	
DUE TO, OR AS A CONSEQUENCE OF (b)	ASCVD	
DUE TO, OR AS A CONSEQUENCE OF (c)	Pneumonia	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J T Lee	DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 10/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): J. T. Lee	22e. ADDRESS: Upper Md. Med. Clinic Havre de Grace		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: Oct. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY: Trinty Cemetery	23d. LOCATION CITY OR TOWN: Belington COUNTY: Barbour STATE: W.Va.
24. FUNERAL DIRECTOR NAME / ADDRESS: Harkins Funeral Home, Inc., 600 Main St., Delta, Pa.	25a. DATE REC'D BY REGISTRAR: OCT 09 1987	25b. REGISTRAR'S SIGNATURE	

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

067960 OCT 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG NO 762

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1 DECEASED NAME (TYPE OR PRINT) FIRST: Vincent	MIDDLE: C.	LAST: TERZIGNI	2a DATE OF DEATH MONTH DAY YEAR: October 2 1987	2b HOUR: 5 45 AM/PM	
3 SEX: M	4 RACE: C White	5 DATE OF BIRTH MONTH DAY YEAR: Oct. 15, 1914	6 AGE (IN YEARS LAST BIRTHDAY): 72 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Italy	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 3818 Marcus Court, Monkton		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): retired	12b KIND OF BUSINESS OR INDUSTRY: Beth. Steel	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Md.		Balto.	YES [X] NO [ ]	1547 E. 36th Street, 21218

14 FATHER'S NAME FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Frank		Terzigni	Julia		Ferri

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
No		213-07-8147	Mrs. Terzigni, 1547 E. 36th St.	21218

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF (b): PROSTATIC CARCINOMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: >2 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a I certify that (I) (this hospital) attended the deceased from 6/6 19 87 to 10/2 19 87 that (I) (we) last saw the deceased alive on 8/23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
Joan T. Edwards	MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10/2/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
JOAN T. EDWARDS	312 BEAR RD FALLSTON MD 21047

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN / COUNTY / STATE
Entombment	10/6/87	Dulaney Valley Maus.	Timonium, Md.

24 FUNERAL DIRECTOR NAME / ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Joseph N. Zannino, 263 S. Conkling St. 21224	OCT 7 1987	Julia Davidson-Landeau

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

068124 OCT -9 87

29763

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO

1. DECEASED NAME (TYPE OR PRINT): MARGARET MAE TESTERMAN
2a. DATE OF DEATH: October 6, 1987
2b. HOUR: 6:20 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: Jan. 14, 1906
6. AGE (IN YEARS LAST BIRTHDAY): 81
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County MD
10. CITY OR TOWN OF DEATH: Bel Air
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 2313 Calvary Road
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: --

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Harford
13c. CITY OR TOWN: Bel Air
13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS / ZIP CODE: 2313 Calvary Road 21014

14. FATHER'S NAME: Joseph -- Leftridge
15. MOTHER'S MAIDEN NAME: Sarah -- Tibbs
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no
(IF YES, GIVE WAR OR DATES): --
16b. SOCIAL SECURITY NO.: 215-28-1093
17. INFORMANT: Carol L.Forbes, 3917 Grier Nursery Road, ADDRESS Street, Md. 21154

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): old age
DUE TO, OR AS A CONSEQUENCE OF: (b): ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF: (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: John D. Yun DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 10-7-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN D. YUN
22e. ADDRESS: 319 Union Avenue, Havre de Grace, Md. 21078

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Oct.9,1987
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, Bel Air
23d. LOCATION CITY OR TOWN: Harford COUNTY: Md. STATE
24. FUNERAL DIRECTOR (NAME): Howard K. McComas III, ADDRESS: Abingdon, Md. 21009
25a. DATE REC'D BY REGISTRAR: OCT 8 1987
25b. REGISTRAR'S SIGNATURE: Julia Davidson-Rendall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner or the county police must be notified.

BP_____

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

070678 NOV -4 87

REG. NO 29764

1. DECEASED NAME (TYPE OR PRINT): FIRST Ada MIDDLE LAST Thompson

2a. DATE OF DEATH: MONTH October DAY 31 YEAR 1987

2b. HOUR 10:30 A.M.

3. SEX: Female

4. RACE: Negro

5. DATE OF BIRTH: MONTH Dec. DAY 13, YEAR 1907

6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS

IF UNDER 1 YEAR: MONTHS DAYS

IF UNDER 24 HRS.: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.

7b. CITIZEN OF WHAT COUNTRY? USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10. CITY OR TOWN OF DEATH: Havre de Grace

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Harford Memorial Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic

12b. KIND OF BUSINESS OR INDUSTRY: Drug Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: HARFORD

13c. CITY OR TOWN: CHURCHVILLE

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 20 Asbury Rd. 21028

14. FATHER'S NAME: FIRST CARROLL MIDDLE LAST THOMPSON

15. MOTHER'S MAIDEN NAME: FIRST CARRIE MIDDLE LAST JOHNSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): —

16b. SOCIAL SECURITY NO.: 218-18-7559

17. INFORMANT: Mildred Davis ADDRESS: Churchville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF (b): Uterus w/ Metastases of Abscess & Sepsis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Anemia - Obstruction with → ileus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/19, 19 87 to 10/31, 19 87, that (I) (we) last saw the deceased alive on 10/31, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Cecil T. Camacho DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED: 10-31-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CECILIO T. CAMACHO

22e. ADDRESS: 2012 Edgewood Rd Edgewood 21040

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: Nov. 5, 87

23c. NAME OF CEMETERY OR CREMATORY: Asbury Meth Cem

23d. LOCATION: CITY OR TOWN Churchville, COUNTY Harford, STATE Md.

24. FUNERAL DIRECTOR: Allen J. Bullock ADDRESS: Havre de Grace, Md.

25a. DATE REC'D BY REGISTRAR: NOV 3 1987

25b. REGISTRAR'S SIGNATURE: Lin Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

10

070344 OCT 30 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 7765

1 DECEASED NAME (TYPE OR PRINT) FIRST: ELIZABETH MIDDLE: Brinker LAST: Van Gosen			2a DATE OF DEATH MONTH DAY YEAR: 10-23-87	2b HOUR: 3:43 PM
3 SEX: Female	4 RACE: Caucasian	5 DATE OF BIRTH MONTH DAY YEAR: Oct. 27, 1916	6 AGE (IN YEARS LAST BIRTHDAY): 70 YRS	IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 BALTIMORE CITY OR COUNTY OF DEATH: HARFORD COUNTY MD	
10 CITY OR TOWN OF DEATH: FALLSTON, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): FALLSTON GEN. HOSPITAL	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Teacher Aid	12b KIND OF BUSINESS OR INDUSTRY: Education	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET ADDRESS / ZIP CODE
Maryland	Harford	Forest Hill	YES [ ] NO [X]	1801 Baldwin Mill Road 21050

14 FATHER'S NAME	15 MOTHER'S MAIDEN NAME
FIRST Augustus MIDDLE Clements LAST Brinker	FIRST Elisabeth MIDDLE LAST Foard

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No		217-09-2814	Max R. VanGosen	same as above

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIOPULMONARY ARREST	
DUE TO, OR AS A CONSEQUENCE OF (b)	CARCINOMA OF COLON WITH MTS.	
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
10/12/87 10/21/87	CARCINOMA - COLECTOMY EXPLOR.	YES [ ] NO [X]	YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) ~~this hospital~~ attended the deceased from 10/11 19 87 to 10/23 19 87 that (I) (we) last saw the deceased alive on 10/23 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
H. McWilliams	MD ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10/23/87

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
H. McWilliams	FGH

23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION CITY OR TOWN COUNTY STATE
Burial	10/26/87	Centre Cemetery	Forest Hill, Harford, Md.

24 FUNERAL DIRECTOR NAME	ADDRESS	25a DATE REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE
M. Gladden Kurtz	Jarrettsville, Md.	OCT 28 1987	[illegible]

069503 OCT 20 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 2977

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to Burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual circumstance, the medical examiner must be notified at once

BP_____

DHMH – 16 25M
(VR A 15 (4)) 9-74

1. DECEASED NAME (TYPE OR PRINT)	FIRST: Louis	MIDDLE: —	LAST: Vidmar		
2a. DATE OF DEATH	MONTH: October	DAY: 16	YEAR: 1987	2b. HOUR: 2 A.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: October 2, 1923	6. AGE (IN YEARS LAST BIRTHDAY): 64 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Cairnbrook Pennsylvania	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Harford County, MD.		
10. CITY OR TOWN OF DEATH: Bel Air	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 1334 Saratoga Drive	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Electrical Engineer	12b. KIND OF BUSINESS OR INDUSTRY: Machinery Mfg.		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Harford Co.	Bel Air	YES [ ] NO [X]	1334 Saratoga Drive 2104

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST: Anton	MIDDLE:	LAST: Vidmar	FIRST: Mary	MIDDLE:	LAST: Frontos

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) 879-2089 ADDRESS
NO	—	204-16-6929	Mrs. Florence Vidmar 1334 Saratoga Drive Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiopulmonary Arrest

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): General Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c): Metastatic colon carcinoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION: STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from October 7 to October 16, 19 87, that (I) (we) saw the deceased alive on October 16 and the above (I) (we) (did not view the body after death). To the best of my (our) knowledge death occurred at the date and hour and from the causes stated

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Robert L. Smith	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	10/16/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Robert L. Smith	Fallston General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION: CITY OR TOWN / COUNTY / STATE
Burial	Oct. 19, 1987	Highview Memorial Gardens	Fallston, Harford Co, Maryland 21047

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Joseph William Foster Joseph William Foster	50 W. Broadway & Williams St. Bel Air, Maryland 21014	OCT 20 1987	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 767

070154 OCT 29 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Fields	MIDDLE: MACK	LAST: Ward	2a. DATE OF DEATH MONTH DAY YEAR: 10/26/87	2b. HOUR: 8:22 A.M.	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 01 23 11	6. AGE (IN YEARS LAST BIRTHDAY): 76 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U S	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.		
10. CITY OR TOWN OF DEATH: Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Painter	12b. KIND OF BUSINESS OR INDUSTRY: Painting	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Maryland	Harford	Bel Air	YES [ ] NO [X]	431 East Broadway 21014

14. FATHER'S NAME FIRST / MIDDLE / LAST	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST
Crockett -- Ward	Perlina - Weatherman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO	17. INFORMANT / ADDRESS
No	--	227-03-2301	Mrs. Naomi T. Ward, 431 E. Broadway, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardio pulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF (b): General Debilitation

DUE TO, OR AS A CONSEQUENCE OF (c): Rule Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that I (the hospital) attended the deceased from 10/25 19 87 to 10/27 19 87 that (I) (we) last saw the deceased alive on 10/25 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did [ ] did not view the body after death.

22b. SIGNATURE: Robert L. Smith DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 10/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	Oct. 29, 1987	Bel Air Memorial Gardens,	Bel Air Harford Md.

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Howard K. McComas III, Abingdon, Md. 21009	OCT 28 1987	

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

068781 OCT 16 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

REG. NO. 2 9 7 0 6

1 DECEASED NAME (TYPE OR PRINT): First: Dorothy; Middle: Reece; Last: Williams

2a DATE OF DEATH: Month 10; Day 13; Year 87

2b HOUR: 10:14 AM

3 SEX: Female

4 RACE: Cauc.

5 DATE OF BIRTH: Month 09; Day 13; Year 27

6 AGE (IN YEARS LAST BIRTHDAY): 60 YRS

If under 1 year: Months; Days

If under 1 day: Hours; Min.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY): North Carolina

7b CITIZEN OF WHAT COUNTRY?: U.S.A.

8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9 BALTIMORE CITY OR COUNTY OF DEATH: Harford MD

10 CITY OR TOWN OF DEATH: Fallston

11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Fallston General Hospital

12a USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Homemaker

12b KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE: MD

13b COUNTY: Harford

13c CITY OR TOWN: Edgewood

13d INSIDE CITY LIMITS? YES [X] NO [ ]

13e STREET ADDRESS / ZIP CODE: 1866 Eloise Lane 21040

14 FATHER'S NAME: First Allen; Middle; Last Eastridges

15 MOTHER'S MAIDEN NAME: First Bertha; Middle; Last Wilcox

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No

(IF YES, GIVE WAR OR DATES)

16b SOCIAL SECURITY NO.: 245-30-7316

17 INFORMANT: Robert A. Williams, 1866 Eloise Lane 21040

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a), b) and c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE a) Respiratory Arrest / Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF b) COPD

Conditions, if any, which gave rise to immediate cause a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a)

19a DATE OF OPERATION

19b CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY? YES [ ] NO [X]

20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) [ ]

21b TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION: STREET; CITY OR TOWN; COUNTY; STATE

22a I certify that (I) (this hospital) attended the deceased from 7/15 19 86 to 10/13 19 87 that (I) (we) last saw the deceased alive on 10/9 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b SIGNATURE: David J Grace DEGREE

ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ]

22c DATE SIGNED: 10-13-87

22d PHYSICIAN'S NAME (TYPE OR PRINT): David Grace MD

22e ADDRESS: 212 So Bond Bel Air, MD

23a BURIAL, CREMATION, REMOVAL (TYPE): Cremation

23b DATE: Oct.14,1987

23c NAME OF CEMETERY OR CREMATORY: Green Mount

23d LOCATION: CITY OR TOWN: Baltimore; COUNTY; STATE: Md.

24 FUNERAL DIRECTOR: ROBERT C. ALTENBURG FUNERAL HOME, INC.
6009 Harford Rd., Baltimore, Md. 21214

25a DATE REC'D BY REGISTRAR: OCT 15 1987

25b REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS: 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed as to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO 2970

870627 NOV -3 '87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the local registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 [illegible] injury, or other traumatic event, the medical examiner must be notified

1. DECEASED NAME (TYPE OR PRINT) FIRST: THERESA	MIDDLE: PALMER	LAST: WILLIAMS	2a. DATE OF DEATH MONTH DAY YEAR: 10 28 87	2b. HOUR: 8 P M
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: MARCH 4, 1899	6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS	IF UNDER 1 YEAR MONTHS / DAYS; IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: HARFORD MD.	
10. CITY OR TOWN OF DEATH: HAVRE DE GRACE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): CITIZENS NURSING HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY:	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD	13b. COUNTY: HARFORD	13c. CITY OR TOWN: HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET ADDRESS / ZIP CODE: 310 BOURBON STREET 21078
14. FATHER'S NAME FIRST: CHARLES	MIDDLE: EDWIN	LAST: PALMER	15. MOTHER'S MAIDEN NAME FIRST: BEADIE	MIDDLE: ESTELLE LAST: SINCLAIR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 213 14 9010	17. INFORMANT ADDRESS: FREDERICK A. WILLIAMS, JR., 1107 REVOLUTION ST., HdG, MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) old age — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY FOR ITEM 18 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE: John D Yun — DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 10/29/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): John D Yun — 22e. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 31OCTOBER87	23c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE: HAVRE de GRACE, HARFORD CO., MD.
24. FUNERAL DIRECTOR NAME ADDRESS: MITCHELL-SMITH FUNERAL HOME PA, HAVRE de GRACE, MD. 21078		25a. DATE REC'D BY REGISTRAR: NOV 2 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Lindsay

BP_____

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